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:1:18-CV-00328-WES-LDA
PROSPECT CHARTERCARE, LLC, ET AL.	:
Defendants.	:

PLAINTIFFS' OMNIBUS MEMORANDUM IN SUPPORT OF THEIR OBJECTION TO DEFENDANTS' MOTIONS TO DISMISS

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Plaintiffs Stephen Del Sesto (as Receiver and Administrator of the St. Joseph Health Services of Rhode Island Retirement Plan) (the "Receiver"), and Gail J. Major, Nancy Zompa, Ralph Bryden, Dorothy Willner, Caroll Short, Donna Boutelle, and Eugenia Levesque, individually as named plaintiffs ("Named Plaintiffs") and on behalf of all class members[1] as defined herein (the Receiver and the Named Plaintiffs are referred to collectively as "Plaintiffs"), submit this omnibus memorandum in support of their objections to all of the motions to dismiss Plaintiffs' claims filed by the various Defendants,[2] both to provide a consolidated statement of facts, and to provide a consolidated response to their arguments that dismissal is required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), on the following grounds:

- alleged lack of standing and ripeness;
- alleged failure to join indispensable parties (Pension Benefit Guaranty Corporation);
- the allegation that Plaintiffs' state law claims are preempted under ERISA;
- the allegation that they cannot be sued for aiding and abetting breach of fiduciary duties based upon ERISA; and
- the allegation that Plaintiffs have no remedies under ERISA on the claim of aiding and abetting.

Plaintiffs herein address all of the Movant Defendants' arguments on these issues, rather than doing so in separate memoranda as to each Defendant, because it

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[1] Contingent upon the Court certifying the Class and appointing them Class Representatives.

[2] There are three motions to dismiss. Defendants Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect Chartercare, LLC, Prospect Chartercare SJHSRI, LLC, and Prospect Chartercare RWMC, LLC (collectively the "Prospect Entities") have filed one motion. Defendants Roman Catholic Bishop of Providence, Diocesan Administration Corporation, and Diocesan Service Corporation (collectively the "Diocesan Defendants") have filled one motion. Finally, Defendant The Angell Pension Group, Inc. has filed a motion to dismiss. Plaintiffs refer to all of these Defendants collectively as the "Movant Defendants."

is more efficient and, in addition, because all of the Movant Defendants have adopted each other's arguments on these issues. However, Plaintiffs are also filing separate memoranda in response to each of the Defendants' motions to dismiss, to separately address the discrete issues raised therein.

I. THE FACTS RELEVANT TO THE MOTION TO DISMISS3

The facts most relevant to the Defendants' motion to dismiss are:

- the specific allegations in the Complaint[4] identifying the Defendants;
- the specific allegations in the Complaint relevant to standing and ripeness; and
- the specific allegations setting forth the Movant Defendants' and St. Joseph Health Services of Rhode Island's misrepresentations and omissions, knowing participation in the fraudulent scheme and conspiracy, and fraudulent transfers.

There is no meaningful way to present the facts concerning the last topic separately as to each Defendant, because so many of them concern meetings and communications in which multiple Defendants were involved, and because they are all relevant to all Movant Defendants' liability for fraudulent scheme and conspiracy. Those allegations all concern actions and statements in furtherance of their common fraudulent scheme and conspiracy, such that they are all imputed to all of the Movant Defendants regardless of whether they actually participated in the specific events. However, in the separate memoranda Plaintiffs specifically identify the facts that are relevant to each of the Movant Defendants' individual liability on Plaintiffs' other claims.

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[3] Plaintiffs have done their best to present only those specific allegations from the Complaint that are relevant to the motions to dismiss.

[4] The references herein to the Complaint are referring to Plaintiffs' First Amended Complaint ("FAC") filed on October 5, 2018 (Dkt. #60).

A. The Defendants[5]

Defendant Prospect Chartercare LLC ("Prospect Chartercare") is a limited liability company that through its 100% owned subsidiaries Prospect Chartercare SJHSRI, LLC ("Prospect SJHSRI")[6] and Prospect Chartercare RWMC, LLC (Prospect RWH)[7] owns and operates health care facilities in Rhode Island, including but not limited to two hospitals, Roger Williams Hospital and Our Lady of Fatima Hospital ("Fatima Hospital"), having acquired them in connection with an asset sale that closed on June 20, 2014 (the "2014 Asset Sale"). Prospect Chartercare currently has two members.[8] Since the 2014 Asset Sale, Prospect Chartercare has also done business under the name CharterCARE Health Partners.[9]

One member of Prospect Chartercare, holding a 15% ownership interest, is Defendant CharterCARE Community Board ("CCCB") which is a non-profit corporation. Prior to the 2014 Asset Sale, CCCB was known as CharterCARE Health Partners, or CCHP.[10] The other member of Prospect Chartercare, holding the remaining 85% ownership interest, is Defendant Prospect East Holdings, Inc. ("Prospect East"), a for-

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[5] Excluding Defendant Rhode Island Foundation, which is irrelevant to the motions to dismiss. The First Amended Complaint attached a flow chart showing corporate relationships between and among the parties to the 2014 Asset Sale.

[6] Not to be confused with St. Joseph Health Services of Rhode Island which until the 2014 Asset Sale owned and operated Fatima Hospital. St. Joseph Health Services of Rhode Island is controlled by the nonprofit corporation CharterCARE Community Board, not the for-profit Prospect Chartercare. FAC ¶¶ 15-16, 19.

[7] Not to be confused with the corporation Roger Williams Hospital that owned and operated Roger Williams Hospital prior to the 2014 Asset Sale, which is owned or controlled by CharterCARE Community Board, not Prospect Chartercare. FAC ¶¶ 17-19.

[8] FAC ¶ 11.

[9] FAC ¶ 415.

[10] FAC ¶ 12.

profit corporation. Prospect East is the wholly owned subsidiary of Defendant Prospect Medical Holdings, Inc.[11]

Defendant Prospect Medical Holdings, Inc. ("Prospect Medical") owns all of the shares of Prospect East.[12]

Defendant St. Joseph Health Services of Rhode Island, Inc. ("SJHSRI") is a non-profit corporation,[13] which owned Fatima Hospital prior to the 2014 Asset Sale. Since then, SJHSRI no longer operates a hospital or otherwise provides health care. It continued to administer the Plan until the Receiver was appointed.[14]

Defendant Roger Williams Hospital ("RWH") is non-profit corporation, which owned the hospital it operated under the name of Roger Williams Hospital prior to the 2014 Asset Sale. Since then RWH ceased operating a hospital or otherwise providing medical care.[15]

At all relevant times CCCB was the ostensible parent company of both SJHSRI and RWH, although Plaintiffs allege that the separate corporate statuses of CCCB, SJHSRI, and RWH must be disregarded to prevent fraud.[16]

Defendant Prospect SJHSRI is a limited liability company that has owned Fatima Hospital since the 2014 Asset Sale. The sole member of Prospect SJHSRI is Prospect Chartercare.[17]

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[11] FAC ¶ 13.

[12] FAC ¶ 14.

[13] FAC ¶ 15.

[14] FAC ¶ 16. Plaintiffs have entered into a settlement with SJHSRI, RWH, and CCCB that is pending approval by the Court. Dkt. # 63.

[15] FAC ¶ 18. As noted, Plaintiffs have entered into a settlement with SJHSRI, RWH, and CCCB that is pending approval by the Court. Dkt. # 63.

[16] FAC ¶ 19.

Defendant Prospect RWH is a limited liability company that has owned Roger Williams Hospital since the 2014 Asset Sale. The sole member of Prospect RWH is Prospect Chartercare.[18]

As used herein, “Old Fatima Hospital” refers to Fatima Hospital when it was owned and operated by SJHSRI, and “New Fatima Hospital” refers to Fatima Hospital since June 20, 2014 when it has been owned and operated by Prospect SJHSRI. “Old Roger Williams Hospital” refers to Roger Williams Hospital when it was owned and operated by RWH, and “New Roger Williams Hospital” refers to Roger Williams Hospital since June 20, 2014 when it has been owned and operated by Prospect RWH.[19]

Defendant CharterCARE Foundation (“CC Foundation”) is a non-profit corporation. It was formerly named CharterCare Health Partners Foundation. Its sole member is CCCB.[20]

Defendant Roman Catholic Bishop of Providence (“Corporation Sole”) is a corporation sole, created by an act of the Rhode Island General Assembly entitled *An Act to Create the Roman Catholic Bishop of Providence, and His Successors, a Corporation Sole*. Since May 31, 2005, Bishop Thomas Tobin has been the President and Chief Executive Officer of Corporation Sole. He was acting within the scope of his

[17] FAC ¶ 20.

[18] FAC ¶ 21.

[19] FAC ¶ 22.

[20] FAC ¶ 24. Plaintiffs have entered into a separate settlement with CC Foundation, which is also pending approval by the Court. Dkt. # 77.

employment by Defendant Corporation Sole with respect to all of his actions and omissions alleged herein.[21]

Defendant Diocesan Administration Corporation ("Diocesan Administration") is a non-profit corporation that aids in administering the affairs of the Roman Catholic Diocese of Providence ("Diocese of Providence") and was instrumental in various matters alleged herein concerning the Diocese of Providence. Since May 31, 2005, Bishop Tobin has been the President and Chief Executive Officer of Diocesan Administration. He was acting within the scope of his employment by Defendant Diocesan Administration with respect to all of his actions and omissions alleged in the Complaint.[22]

Diocesan Service Corporation ("Diocesan Service") is a non-profit corporation that aids in administering the affairs of and services provided by the Diocese of Providence and was instrumental in various matters alleged herein concerning the Diocese of Providence. Since May 31, 2005, Bishop Tobin has been the President and Chief Executive Officer of Diocesan Service. He was acting within the scope of his employment by Defendant Diocesan Service with respect to all of his actions and omissions alleged in the Complaint.[23]

Defendant The Angell Pension Group, Inc. ("Angell") is a for-profit corporation which since 2005 provided actuarial services in connection with the Plan, and, at least

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[21] FAC ¶ 26.

[22] FAC ¶ 27.

[23] FAC ¶ 28.

since 2011, provided administrative services which included dealing directly with and advising Plan participants, both before and after the 2014 Asset Sale.[24]

B. The Facts Relevant to Standing and Ripeness

The Plan is a defined benefit plan established by SJHSRI with over 2,700 participants.[25] In August 2017, Defendant St. Joseph Health Services of Rhode Island ("SJHSRI") petitioned ("the "Receivership Petition") the Rhode Island Superior Court to place the Plan into receivership, in the case captioned *St. Joseph Health Services of Rhode Island, Inc. v. St. Josephs Health Services of Rhode Island Retirement Plan, as amended*, PC-2017-3856 (the "Receivership Proceedings").[26]

Attorney Stephen Del Sesto was appointed Receiver of the Plan by the Superior Court.[27] He is also the Administrator of the Plan.[28] The Named Plaintiffs are all participants in the Plan.[29]

The Receivership Petition alleged that the Plan was severely underfunded.[30] Specifically, SJHSRI stated as follows:

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[24] FAC ¶ 29.

[25] FAC ¶ 1.

[26] FAC ¶ 2.

[27] FAC ¶ 2.

[28] FAC ¶ 2.

[29] FAC ¶¶ 3-9.

[30] Dkt. # 65-1 (Receivership Petition) ¶ 10 ("Pursuant to the Actuarial Report, the Plan is severely underfunded and requires additional capital of over $48,000,000 to reach a 100% funding level."). The Receivership Petition, including exhibits, should be considered in connection with the resolution of Defendants' motions to dismiss, for several reasons: 1) it is extensively referred to in the First Amended Complaint and, therefore, referable under Clorox Co. P.R. v. Proctor & Gamble Commercial Co., 228 F.3d 24, 32 (1st Cir. 2000) ("Although much of the evidence contained in the record is out-of-bounds in reviewing a 12(b)(6) dismissal, it is well-established that in reviewing the complaint, we 'may properly consider the relevant entirety of a document integral to or explicitly relied upon in the complaint, even though not attached to the complaint, without converting the motion into one for summary judgment.'") (quoting Shaw v. Digital Equip. Corp., 82 F.3d 1194, 1220 (1st Cir. 1996)); 2) it is a court record of which

> Petitioner is informed and believes that the Plan is unsustainable absent court intervention and will be unable to pay all accrued benefits as they become due.

To substantiate that conclusion, the Petition attached an actuarial report prepared by Defendant Angell.[31] The report estimated the present value of the Plan's liability as of December 31, 2016 to be $126,717,720.[32] That report stated that the present value of Plan assets as of July 1, 2016 was $86,780,384.[33] The report estimated that the sum of $43,032,480 would be needed as of July 1, 2016 to reach a 100% funding level.[34] The report concluded that the Plan was only 68.5% funded.[35]

The Receivership Petition noted, however, that that this calculation assumed a future annual rate of investment return on Plan assets of 7.75%, and that "going forward there is concern that 7.75% projected annualized return is unlikely to be sustained in the long term."[36] The Receivership Petition stated that "[a]pplying a lower anticipated annual rate of return would result in a higher underfunding projection."[37]

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the Court may take judicial notice. See Lynch v. Bd. of State Examiners of Electricians, 218 F. Supp. 2d 3, 6 n.7 (D. Mass. 2002) ("Although the state court decisions were not appended to the complaint, the plaintiff did attach the Appeals Court decision to his opposition to the motion to dismiss. The authenticity of these decisions is not disputed by either party, and the decisions are also a matter of public record. The Court may therefore properly consider these matters in deciding motion to dismiss."); and 3) the relevant exhibits are authored by Defendant Angell and adopted by Defendant SJHSRI.

[31] Dkt. # 65-1 (Receivership Petition, without exhibits) ¶ 9. The Receivership Petition attached an actuarial report as Exhibit 2 (attached hereto as Tab 1).

[32] Tab 1 at 5.

[33] Tab 1 at 15.

[34] Tab 1 at 15.

[35] $86,780,384 divided by $126,717,720 = .685 (rounded).

[36] Dkt. #65-1 (Receivership Petition) ¶ 10.

[37] Dkt. #65-1 (Receivership Petition) ¶ 10.

The Receivership Petition then addressed what SJHSRI wanted to be done with the Plan, given its grossly underfunded status. SJHSRI informed the Court:

> Absent judicial intervention, Petitioner anticipates that the Plan will be terminated and its funds distributed in a manner that will result in current Plan beneficiaries receiving approximately 60% of their accrued benefits and all others receiving nothing.[38]

The Receivership Petition stated that ""[SJHSRI] requested that Angell perform analyses of different Plan termination and liquidation scenarios to facilitate an evaluation of options for the Plan and its beneficiaries,"[39] and attached those analyses.

The Receivership Petition labelled the first analysis the "Initial Termination Analysis" and explained its conclusions as follows:

> The Initial Termination Analysis demonstrated that upon an immediate termination of the Plan, **beneficiaries currently receiving benefits would receive a payout of approximately 60% of their accrued benefits** and all other beneficiaries would receive no distributions whatsoever.[40]

The Initial Termination Analysis noted that there were 2,724 Plan participants in total, and quantified the "beneficiaries currently receiving benefits" as 1,382 Plan participants, and "all other beneficiaries" as 1,442 Plan participants.[41] Thus, under the Initial Termination Analysis, out of the 2,724 Plan participants, 1,382 would receive *only 60% of their benefits*, and the remaining 1,442 Plan participants would receive *nothing*. In other words, all of the Plan participants would suffer very substantial injuries to their pension benefits.

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[38] Dkt. # 65-1 (Receivership Petition) ¶ 20.

[39] Dkt. # 65-1 (Receivership Petition) ¶ 11.

[40] Dkt. # 65-1 (Receivership Petition) ¶ 12 (emphasis supplied).

[41] Dkt. # 65-1 (Receivership Petition) Exhibit 3 (attached hereto as Tab 2) at 4.

SJHSRI advised the Superior Court that this was the scenario that would occur "absent court intervention."[42] SJHSRI went on to state, however, that "[SJHSRI] believes that such an outcome represents the least favorable result."[43] As an alternative to immediate termination of the Plan, SJHSRI asked the state court to cut the benefits of *all Plan participants by 40%*, and to permit the Plan to continue *indefinitely*, to enable the Plan to earn investment rates of return.[44]

In support of that recommendation, the Petition attached additional analyses prepared by Defendant Angell as of July 1, 2017, setting forth the effect of such an across-the-board 40% reduction under two different scenarios, 1) if the Plan continued, such that its assets could earn investment rates of return, or 2) plan termination, which would be accomplished by substituting the Plan's obligations for insurance company annuities purchased with the Plan's assets. As to plan continuation, these actuarial calculations concluded that, even with a 40% across-the-board cut in benefits, the minimum annual rate of return on investments that would avoid plan insolvency was 6.66%.[45] In other words, if that rate of return were obtained, all of the Plan participants would suffer an injury in the amount of 40% of their original benefits, but a lower rate of return would necessitate an even greater across-the-board cut in benefits than 40%.

Under the scenario of Plan termination, Angell estimated that if the Plan were restructured by reducing benefits across-the-board by 40%, and the Plan were

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[42] Dkt. # 65-1 (Receivership Petition) ¶ 20.

[43] Dkt. # 65-1 (Receivership Petition) ¶ 12.

[44] Dkt. # 65-1 (Receivership Petition) ¶ 15 & p. 7 ("WHEREFORE, Petitioner respectfully requests that … (3) that the request for appointment of a permanent receiver and for an immediate 40% uniform reduction in benefits be set for hearing [in] thirty (30) days."); FAC ¶ 54.

[45] Tab 1 (actuarial calculations) at 1.

terminated with annuities purchased at an interest rate of 2.58%, then there were would be sufficient funds to pay only 67% of the benefits (already reduced by 40%) that were due, virtually all (99%) of which would go to existing retirees and fully vested employees, leaving the remaining 1,442 Plan participants with nothing.[46] Once again, all of the Plan participants would suffer grievous injury.

In other words, Defendants SJHSRI and Angell presented no scenario under which all or any of the Plan participants would avoid very significant injuries.

C. The Movant Defendants' and SJHSRI's Misrepresentations and Omissions, Knowing Participation in the Fraudulent Scheme and Conspiracy, and Fraudulent Transfers

In their motions to dismiss, none of the Movant Defendants question the sufficiency of the allegations in the Complaint that SJHSRI committed fraud. Accordingly, that is not disputed for purposes of their motion to dismiss.[47] Although not at issue, those allegations must be identified to demonstrate the Movant Defendants' participation in the fraudulent scheme and conspiracy to defraud the Plan participants. Moreover, they are a crucial part of "the array of circumstances described in the complaint" that together support the reasonable inferences of the Movant Defendants' liability for purposes of the motion to dismiss. Rodríguez–Reyes v. Molina–Rodríguez, 711 F.3d 49, 57 (1st Cir. 2013) (The motion to dismiss should be denied if "the array of circumstances described in the complaint suffices to support an inference.").

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[46] Tab 1 (actuarial calculations) at 3.

[47] These undisputed allegations are relevant to the Movant Defendants' motions to dismiss for several reasons, including because they are liable for them under Plaintiffs' claims for fraudulent scheme and conspiracy, and they independently satisfy the requirement of civil conspiracy for an underlying intentional tort. See Read & Lundy, Inc. v. Washington Trust Co. of Westerly, 840 A.2d 1099, 1102 (R.I. 2004) (civil conspiracy is "a means for establishing joint liability for other tortious conduct; therefore, it 'requires a valid underlying intentional tort theory.'").

Accordingly, they are included herein for that purpose, notwithstanding that they themselves are not at issue.

The Plan began in 1965 when Corporation Sole, Diocesan Administration, and Diocesan Service established a defined benefit pension covering employees of the Diocesan Defendants and SJHSRI (the "Diocesan Plan").[48] The Diocesan Plan initially was funded mostly by the Plan participants' employers, and in part by employee contributions.[49] Beginning in 1973, however, employee contributions were no longer required or permitted.[50] The Diocesan Plan documents went through iterations over the ensuing years until 1995, with at least two constants: they were never provided to the Plan participants, and they arguably relieved the Diocesan Defendants and SJHSRI of any obligation to make contributions.[51] In 1995, and without any disclosure to Plan participants, the portion of the Diocesan Plan that covered SJHSRI's employees was split off into its own Plan, the St. Joseph Health Services of Rhode Island Retirement Plan (the "Plan"), which subsequently also went through several iterations, none of which were provided to the Plan participants and which were structured to arguably relieve SJHSRI of any obligation to make contributions to the Plan.[52]

Although Plan participants were never given the Plan documents, participants were provided with a great many other documents that made representations concerning the Plan, which SJHSRI offered to entice new employees and to retain

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[48] FAC ¶ 211.

[49] FAC ¶ 212.

[50] FAC ¶ 213.

[51] FAC ¶¶ 213, 218, 221.

[52] FAC ¶¶ 214, 218, 221.

existing employees.[53] Indeed, in October 1990, SJHSRI's then-actuary Watson Worldwide made a presentation to the SJHSRI board noting that "recruiting and retention of employees" was the first purpose of the Plan.[54]

SJHSRI management and directors were informed on numerous occasions that SJHSRI's employees did not understand the provisions of the Plan, but chose to do nothing about it. For example:

a. In a memorandum to SJHSRI Controller Paul Beaudoin on February 3, 1997, Watson Worldwide offered to update the employee booklet on the Plan. Watson Worldwide dealt directly with Plan participants and made presentations to them concerning the Plan. Nevertheless, they stated that "[i]t is our understanding that employees do not understand or know very much about the Plan." Management declined to update the booklet.[55]

b. On February 2, 1990, SJHSRI's Vice President for Human Resources David DeJesus sought but was denied authority to provide Plan participants with an annual statement that would contain the information that ERISA requires for annual plan statements. SJHSRI never provided Plan participants with such information, which would have included disclosing the unfunded status of the Plan.[56]

c. At a meeting of the Investment Committee of the CCCB Board of Trustees on May 4, 2012, after board members were informed that SJHSRI was not required by ERISA to make contributions to the Plan, one board member asked whether Plan participants "truly understood the funding status of the Plan and the impact of the Plan being a Church Plan (non ERISA)." The response by CCCB President and Chief Executive Officer Belcher was that he "believed that staff are aware and that this subject was discussed at employee forums." However, this information was never mentioned in any written presentation to any employees and there is no evidence it was ever even orally conveyed at any employee forums

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[53] FAC ¶¶ 256-57.

[54] FAC ¶ 256.

[55] FAC ¶ 258(a).

[56] FAC ¶ 258(b).

> or to any employees or other Plan participants at any other occasion.[57]

These communications took many forms. They included descriptions of the Plan in detailed booklets, less-detailed handouts and tri-fold pamphlets specific to the Plan, employee handbooks, presentations ("PowerPoints") used in slideshows, and memoranda and letters from SJHSRI management to employees.[58]

In addition, SJHSRI and Defendant Angell communicated with specific employees concerning the Plan and a specific employee's benefits through various communications as described below.[59]

A detailed booklet entitled "Retirement Plan for Employees of the Diocese of Providence," issued prior to 1973, described the pension benefits being provided to the employees of SJHSRI as of January 1, 1973 and stated:

> It is the desire of the diocese, its parishes and institutions, to make provision for its employees in retirement. Indeed, we have always had a sympathetic concern for the welfare of our employees and are confident that this implementation of that concern will provide the necessary sense of security and peace of mind that all envision.
>
> * * *
>
> Q. What does the Diocese contribute?
>
> A. The Diocese contributes the entire cost of the benefits you have earned prior to the adoption of the Retirement Plan. **The Diocese will also contribute an additional amount which, when added to your contributions, will meet the cost of benefits you will earn during the remaining years of your employment.**
>
> * * *

[57] FAC ¶ 258(c).

[58] FAC ¶ 263.

[59] FAC ¶ 264.

Q. How will my Retirement Benefit be paid?

A. You will receive a check each month beginning on your retirement date and terminating with the payment preceding your death.[60]

[emphasis supplied]

Another detailed booklet, entitled Saint Joseph's Hospital Retirement Plan (1973 edition) stated:

This booklet has been prepared to inform you about your Saint Joseph's Hospital Retirement Plan.

* * *

One of the most important sources of your income will be our Retirement Plan . . . .

* * *

HIGHLIGHTS OF THE PLAN

The Hospital will pay the entire cost of the Plan beginning January 1, 1973.

* * *

COST OF THE PLAN

5. Do I make any contributions to the Plan?

No. The Hospital will pay the entire cost of the Plan beginning January 1, 1973 – not only your pension but also all actuarial, legal and investment expenses incurred in the administration of the Plan.[61]

On or about February 6, 1978, SJHSRI's then President A. Edward Azevedo sent a memorandum to employees, urging them not to unionize and describing the benefits

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[60] FAC ¶ 265.

[61] FAC ¶ 266.

SJHSRI already provided through the Diocesan Plan. This memorandum contrasted the Hospital's pension benefits with what SJHSRI characterized as "vague promises" of union organizers and stated:

> Know the facts when someone asks you to sign a union authorization card. The union organizer makes vague promises, but the facts are that your Hospital has, on a regular basis, increased your wages and improved your benefits.
>
> For example, during the past five years, the following improvements have been made by the Hospital:
>
> * * *
>
> Pension Plan – Improved from contributory to non-contributory effective January 1973. Plan improved again effective January 1977; **Hospital pays full cost of the plan**.[62]
>
> [Emphasis supplied]

Another detailed booklet, entitled "RETIREMENT PLAN ST JOSEPH HOSPITAL Providence/North Providence, Rhode Island (1982 Edition)" contains the following statement, in question and answer format:

> WHO WILL PAY FOR MY BENEFITS?
>
> The Hospital pays the entire cost of your benefits earned after 1972 and before 1965. You and the Hospital shared the cost between 1965 and 1972.
>
> **Each year independent actuaries calculate the amount of money which the Hospital will pay to the Plan Trustee. This money is then set aside and invested to provide each eligible employee with a pension at retirement**.[63]
>
> [Emphasis supplied]

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[62] FAC ¶ 267.

[63] FAC ¶ 268.

The preface to the booklet was a letter to employees signed by then-SJHSRI President Azevedo, which concluded with the "hope that this Plan will be evidence of our personal interest in your welfare, not only while actively in our employ but after you retire to enjoy the rewards of a long and productive life."[64]

Similar language was included in the next edition of that booklet, captioned "St. Joseph Hospital Retirement Plan Providence/North Providence, Rhode Island (1986 Edition)", which stated:

> The St. Joseph Hospital Retirement Plan was established to help you make your retirement years economically more secure. Since its inception in 1965, the Hospital has made many improvements to the Plan. The most recent improvements became effective on July 1, 1985.
>
> **The Hospital pays the entire cost of the Plan and no contributions are required by you.**
>
> Your Retirement Plan will give you a lifetime monthly income when you become eligible to retire. In addition, the Plan may provide benefits to your spouse or beneficiary after your death.
>
> * * *
>
> WHO PAYS FOR MY BENEFITS?
>
> **The Hospital pays the entire cost of your benefits. Each year independent actuaries calculate the amount of money which the Hospital will pay to the Plan Trustee. This money is then set aside and invested to provide each eligible employee with a pension at retirement.**[65]
>
> [Emphasis Supplied]

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[64] FAC ¶ 268.

[65] FAC ¶ 269.

The highlighted language was repeated in a subsequent revision of that booklet in 1988 and draft revisions in 1993, 1995, 1996, and 1999.[66] It appears that SJHSRI stopped revising that booklet but continued to use it over time. During the period it was in use, SJHSRI never omitted or in any way contradicted this language.[67]

Prior to 1995, the Diocese's Retirement Board sent terminated or retiring employees of SJHSRI documents entitled "STATEMENT OF INFORMATION FOR TERMINATED EMPLOYEES WITH VESTED RIGHTS". For example, one such form dated January 15, 1994 stated:

> According to our records, your service with St. Joseph Hospital prior to your termination of employment on 12/3/92 entitles you to a benefit at age 65 from the Diocese of Providence Retirement Plan – St. Joseph Hospital (the "Plan"). The amount of this benefit is $192.42 per month commencing on 4/1/2020 and **payable to you for as long as you live**.[68]
>
> [Emphasis supplied]

From time to time SJHSRI offered seminars or made presentations to Plan participants to explain their benefits, and in the process assured Plan participants that they could rely on their pensions.[69] For example, on November 15 & 16, 1995, and again on March 4, 1998, SJHSRI, through Dan Hanlon and Phyllis Cabral of SJHSRI's human resource department, and SJHSRI's actuary and direct representative with Plan participants, Ed Groden and Gail Cohen of Watson Worldwide, showed Plan participants a PowerPoint that stated that "[c]omputations [are] made annually to ensure assets are sufficient to meet current and expected future benefit obligations," without

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[66] FAC ¶ 271.

[67] FAC ¶ 271.

[68] FAC ¶ 272.

[69] FAC ¶ 273.

disclosing that in fact SJHSRI claimed to have no obligation to follow the funding recommendations that were the product of those computations.[70]

On October 24, 1996, SJHSRI's President and Chief Executive Officer sent a letter to employees of SJHSRI, which stated that he was "particularly pleased about the Pension Plan improvements," but neglected to disclose the fact that SJHSRI employees were no longer part of the Diocesan Plan.[71]

That same letter claimed that the Plan available to SJHSRI employees "is as good or better than those of many other organizations in the region," without disclosing that, unlike the case with the defined benefit plans of most organizations, SJHSRI claimed that the Plan was not governed by ERISA, and thus would not have insurance coverage against insolvency provided by the Pension Benefit Guaranty Corporation ("PBGC").[72]

From time to time thereafter, SJHSRI, the then-incumbent Bishop acting on behalf of Defendants Corporation Sole, Diocesan Administration, and Diocesan Service, communicated with SJHSRI employees concerning the Plan in terms that falsely reassured Plan participants that the Bishop and Diocese of Providence had ongoing involvement in the Plan.[73]

For example, a handout was provided to Plan participants, entitled "RETIREMENT PLAN HIGHLIGHTS," that purported to summarize the Plan as of

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[70] FAC ¶ 273.
[71] FAC ¶ 274.
[72] FAC ¶ 275.
[73] FAC ¶ 276.

January 1, 1998 (three years after the split off of the Plan from the Diocesan Plan), and referred to the Bishop's and Diocese's ongoing involvement in the Plan:

> Who administers the Plan?
>
> The Roman Catholic Bishop of Providence has appointed a Retirement Board to administer the Plan. The Board will establish rules and regulations for the administration of the Plan, and will be responsible for resolving any disputes concerning Plan operation.
>
> Who administers the Retirement Fund?
>
> The Diocese has established a Trust Fund with Fleet Investment Services. The Trustee of the Fund will hold, invest, and distribute the money in accordance with the terms and provisions of the Plan and Trust Agreement.[74]

The statement that Plan assets were held in a trust established by the Diocese was false, since in connection with the separation of the two plans in 1995, a new trust was established by SJHSRI, but SJHSRI did not inform Plan participants of the separation, much less that only a portion of the Diocesan Plan assets were transferred to the new trust for the Plan alone.[75]

That handout also stated in part:

> Retirement is a time in life we all look forward to with great anticipation, a time when we have the opportunity to do the things we most enjoy. Maybe you have your sights set on traveling across the country? Or perhaps spending time with the grandchildren? But whether your retirement plans involve relaxing on the beach—or on the golf course—one thing's for certain: *You'll need money to achieve them.*
>
> That's why St. Joseph Health Services of Rhode Island offers the Retirement Plan to all eligible employees. **The Retirement Plan is designed to help you meet your retirement savings goals by**

[74] FAC ¶ 277.

[75] FAC ¶ 277.

> **providing you with a monthly annuity during retirement. And the best part of all is you contribute nothing for this benefit—it's paid for completely by the Hospital.** In this way, your Retirement Plan benefit is an important part of your total retirement income. And when combined with your Social Security benefit and your personal savings, this benefit can provide the financial security you need to follow through on your retirement plans.
>
> * * *
>
> *Retirement Payment Options*
>
> What are the payment options?
>
> **You may choose a Life Annuity option, which provides you a fixed monthly payment throughout your lifetime.** Or you may choose one of four Joint and Survivor options (100%, 75%, 66 2/3%, or 50%), which pay a reduced monthly payment throughout your lifetime, and continue payments to your beneficiary after you die.
>
> You may also choose a Ten-Year Guarantee option, which provides at least 120 guaranteed monthly payments (for a total of ten years) to you and your beneficiary.[76]
>
> [Italics in the original and bolded emphasis supplied]

A pamphlet provided to Plan participants, entitled "Questions And Answers About The St. Joseph Health Services Retirement Plan," and dated "Effective 7/1/2001", stated *inter alia*:

> Q: What forms of payment are available to me?
>
> A: The normal form of payment is a life annuity. **Under this form of payment, you will receive your monthly pension payments for as long as you live.** All pension payments stop when you die.[77]
>
> [Emphasis added]

[76] FAC ¶ 278.

[77] FAC ¶ 279.

From time to time, SJHSRI provided statements to Plan participants discussing and quantifying their Plan benefits. Thousands of these statements stated *inter alia*:

> St. Joseph Health Services of Rhode Island is pleased to give you this statement showing your estimated benefits in the Retirement Plan as of [insert date]. **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.**
>
> * * *
>
> 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.[78]
>
> [Emphasis added]

Similarly, in September of 2003, SJHSRI provided employees with a handout entitled "Understanding Your St. Joseph Health Services of Rhode Island Pension Statement," which set forth the following as "Pension Basics":

> Pension Basics
>
> Simple
>
> - Participation is automatic
>
> **Secure**
>
> - Assets in trust fund
> - **No investment risk to you**
>
> Valuable
>
> - Hospital pays the entire cost
> - Non-contributory Defined Benefit (DB) Plan
> - Rewards long service employees[79]
>
> [Emphasis supplied]

The grossly underfunded status of the Plan is due in large part to SJHSRI's choosing not to fund the Plan when it was necessary to do so because the Plan did not meet investment targets, or, indeed, incurred substantial investment losses.[80] In other

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[78] FAC ¶ 280.

[79] FAC ¶ 281.

[80] FAC ¶ 281.

words, SJHSRI in fact placed the "investment risk" on Plan participants, contrary to the representation that they bore "no investment risk."[81]

From time to time, SJHSRI provided employee handbooks to its employees. One dated "April, 2004," stated *inter alia*:

> Pension Plan
>
> Regular full-time and regular part-time employees are eligible to participate in the SJHSRI pension plan. If an Employee is paid for 1,000 hours or more per retirement plan year he/she will enter the Plan on the first of the calendar month following the first anniversary of the employee's employment. **Pension Plan is fully paid by the Hospital.** Vesting is after 5-years of Continuous Service. To help you estimate your potential benefit at retirement, pension statements are distributed annually.[82]
>
> [Emphasis supplied]

Beginning in 2009, SJHSRI also administered a defined contribution plan (a "403(b) Savings Plan"), which gave employees the right to make pre-tax contributions and to control their investments.[83] With that plan, SJHSRI on or about July 9, 2007, provided a handout which answered the question "is there ever a time when benefits can be lost or denied" by stating:

> The value of your account depends on the value of Plan investment. This is why your account must be invested carefully.[84]

With respect to the defined benefit plan, which is the Plan involved in this case, however, SJHSRI never told Plan participants that their benefits could be "lost" or

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[81] FAC ¶ 282.

[82] FAC ¶ 284.

[83] FAC ¶ 285.

[84] FAC ¶ 285.

diminished if the Plan assets suffered investment losses.[85] To the contrary, as noted above, SJHSRI affirmatively represented that, under the defined benefit plan, there is "[n]o investment risk to you."[86]

The explanation of the 403(b) Savings Plan also stated:

> The Company reserves the right, of course, to amend the Plan or to discontinue contributions to it. No amendment can reduce the amount in your account or eliminate any of the benefit form options offered in the Plan. **If the Company permanently discontinues contributions to the Plan, you will be notified** and you will become 100% vested in your account.[87]
>
> [Emphasis supplied]

No such disclosure was made in connection with the Plan.[88]

On January 28, 2011 SJHSRI through Darlene Souza prepared a PowerPoint presentation to one of the employee unions, the Federation of Nursing and Health Care Professionals ("FNHCP"), seeking union approval for a plan to freeze SJHSRI's defined benefit plan and substitute a defined contribution plan going forward for all employees belonging to FNHCP.[89] This presentation stated that the proposed freeze was necessary to protect the assets of the Plan. However, management represented in the PowerPoint that the defined benefits earned on the years of service already performed "will not be affected."[90]

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[85] FAC ¶ 285.
[86] FAC ¶ 285.
[87] FAC ¶ 286.
[88] FAC ¶ 286.
[89] FAC ¶ 287.
[90] FAC ¶ 287.

On January 2, 2012, the Chairman of the Investment Committee for CCCB's Board of Trustees informed CCCB's head of Personnel, Darlene Souza, and CCCB's Chief Financial Officer Conklin, that the Board of Trustees and management must consider the option of terminating the Plan and distributing the assets with a *pro rata* reduction in benefits.[91]

On December 31, 2012, Ms. Souza emailed Mr. Conklin and CCCB's Chief Executive Officer Belcher, wished them a "Happy New Year," and then advised them of what she called the "potentially good news" that, according to her reading of the Plan documents, they could "terminate the plan without a solvency issue," and:

- deprive 1,798 (out of a total of 2,852) Plan participants of any benefit whatsoever,
- pay benefits to an additional 744 Plan participants of only 88% of what they were due;
- pay full benefits only to the remaining 1,054 Plan participants who had already reached normal retirement age; and
- improve SJHSRI's balance sheet by over $29,000,000 by eliminating its liability for the unfunded portion of the Plan.[92]

However, in the same email, Ms. Souza advised Messrs. Conklin and Belcher that there was a downside to the Plan termination, which was that other hospitals with supposed Church Plans had attempted to terminate their plans just as she was proposing, but those hospitals had been sued in class actions, and one of those cases had a pending settlement that obligated the hospital to pay a significant amount of the unfunded benefits, notwithstanding its purported Church Plan status.[93]

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[91] FAC ¶ 363.

[92] FAC ¶ 364.

[93] FAC ¶ 365.

Accordingly, Ms. Souza warned that if SJHSRI terminated the Plan and distributed reduced benefits, "we are exposed to a class action lawsuit" by the Plan participants who received no benefits, which could expose SJHSRI to "$30-$35m" as damages, which "would potentially erode the $29m fiscal savings" resulting from eliminating SJHSRI's funding liability by termination of the Plan.[94]

Defendant Angell agreed to deal directly with Plan participants, and Angell also worked with Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East in crafting presentations, and dealt directly with employees of Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East at New Fatima Hospital informing them of their rights under the Plan.[95]

Angell never informed Plan participants of the Plan's underfunded status or the fact that SJHSRI was not making necessary contributions.[96] To the contrary, Angell's statements to Plan participants implied and in many cases directly represented that their pension benefits were secure.[97] For example, Angell continued to provide individual Plan participants with annual statements that set forth specific projected lifetime benefits, which Angell and all of the other Defendants knew could not be relied upon.[98]

On April 29 & 30, 2014, shortly before the sale of Fatima Hospital was approved, representatives of Angell (including at least Mary Pat Moran), SJHSRI, RWH, and

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[94] FAC ¶ 366.
[95] FAC ¶ 288.
[96] FAC ¶ 290.
[97] FAC ¶ 290.
[98] FAC ¶ 291.

CCCB (including at least Darlene Souza) again participated in PowerPoint Presentations to SJHSRI employees intended to reassure them that the sale of the hospital to Prospect Medical would not affect their pension benefits.[99] In those presentations, the employees were shown a PowerPoint presentation which informed them that the terms of agreement for SJHSRI's joint venture with CCCB and Prospect Medical "includes a $14 Million contribution to the Pension Plan to stabilize plan assets," and were shown a sample final benefit statement that again acknowledged that "[y]our pension benefit is an important part of your future retirement income," and reassured them that "[t]he Hospital pays the entire cost of the Plan," with payment options that included annuity payments for life.[100] At that time, Defendants SJHSRI, RWH, CCCB, and Angell already knew that the $14 million contribution was not even remotely sufficient "to stabilize plan assets."[101]

Defendants SJHSRI, RWH, CCCB, and Angell also knew that the statement that "the Hospital pays the entire cost of the Plan" was also false and deceptive, on at least two levels. "[T]he entire cost of the Plan" includes funding the Plan, and, therefore, the statement was false because no one was funding the Plan. Moreover, given the timing of the presentation (two months before the closing) and the purpose to reassure employees concerning the effect of the 2014 Asset Sale on their pension benefits, the employees reasonably concluded that the "Hospital" referred to was New Fatima Hospital under the ownership and operation of Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East.

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[99] FAC ¶ 292.

[100] FAC ¶ 292.

[101] FAC ¶ 294.

Moreover, Defendants SJHSRI, RWH, CCCB, and Angell knew that the Plan, which this PowerPoint presentation referred to as an "important part of [the Plan participants'] future retirement income" was grossly underfunded, and the option to choose annuity payments for life was illusory if not an outright lie, because Plan assets would run out long before most of the Plan participants or their designated beneficiaries would have passed away.[102]

On June 20, 2014, Prospect Chartercare filed a "fictitious business name statement" with the Rhode Island Secretary of State, stating that it would operate under the "fictitious name" of CharterCARE Health Partners, which was the same name under which SJHSRI, RWH, and CCCB had operated Old Fatima Hospital and Old Roger Williams Hospital from 2009 right up to the day of the closing of the 2014 Asset Sale.[103]

On August 12, 2014, nearly two months after Prospect Chartercare, and Prospect SJHSRI took over ownership and operation of New Fatima Hospital, Defendant Angell (through Mary Pat Moran) 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.[104] Defendants SJHSRI, RWH, CCCB, Angell, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East had attempted to structure the 2014 Asset Sale to avoid any obligations by Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East under the Plan, and the Asset Purchase Agreement expressly stated that

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[102] FAC ¶ 296.

[103] FAC ¶ 415.

[104] FAC ¶ 306.

responsibility for the Plan after the asset sale closed would remain with SJHSRI.[105] Thus, Angell was seeking instruction from Prospect Chartercare concerning the information to provide to Plan participants, even though Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East claimed to have no liability for the Plan.[106]

Brenda Ketner of Prospect Chartercare passed this inquiry on to Darleen Souza and Susan Desmarais of Prospect Chartercare, and acknowledged the deceitful course of conduct they were pursuing by stating that "I think the less 'formal' communication on this the better."[107]

With the agreement and support of Ms. Souza and Ms. Desmarais, Brenda Ketner instructed Angell *not* to provide Plan participants with the information they were seeking concerning the solvency of the Plan.[108] Moreover, with the agreement and support of Ms. Souza and Ms. Desmarais, Brenda Ketner 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."[109] Angell accepted and followed these instructions.[110]

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[105] FAC ¶ 306.
[106] FAC ¶ 306.
[107] FAC ¶ 307.
[108] FAC ¶ 308.
[109] FAC ¶ 308.
[110] FAC ¶ 310.

Both Angell (at least through Mary Pat Moran) and Prospect Chartercare (at least through Brenda Ketner, Darleen Souza, and Susan Desmarais) knew that this statement was false, incomplete, misleading, and intended to mislead.[111] They knew they could very well "speak to the future [in]solvency of the plan," because their own calculations predicted that the Plan would not have sufficient funds to pay Plan participants the benefits to which they were entitled, and knew that SJHSRI for years had been disregarding Angell's funding recommendations and making no contributions, and that once the asset sale went through, SJHSRI would have insufficient funds to make the actuarial-recommended contributions even if it wanted to.[112] Thus, it was an intentionally fraudulent and material omission for Angell to refuse to "speak to the solvency of the Plan," to fail to disclose to Plan participants that Angell knew the Plan was grossly underfunded, and that SJHSRI for years had been disregarding Angell's funding recommendations and making no contributions, while at the same time reassuring Plan participants that "plan administrators review the annual recommended funding as advised by the plan's actuaries each year," and that "[t]here is also an investment committee that reviews and monitors the plan on an ongoing basis."[113]

On or about April 13, 2016, nearly two years after the asset sale, Angell worked with SJHSRI, CCCB, and Prospect Chartercare to prepare and make another PowerPoint presentation, this time at New Fatima Hospital, to former-employees of SJHSRI who were now employed at New Fatima Hospital, concerning the Plan and the rights of Plan participants, which again acknowledged that "[y]our pension benefit is an

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[111] FAC ¶ 309.

[112] FAC ¶ 309.

[113] FAC ¶ 309.

important part of your future retirement income," and again reassured them that "[t]he Hospital pays the entire cost of the Plan," with payment options that included annuity payments for life.[114] Prospect Chartercare participated in this presentation even though it claimed to have no liability for the Plan.

These Defendants knew that the "Hospital," which for nearly two years had been owned and operated by Prospect Chartercare and its subsidiary Prospect SJHSRI, claimed it had no obligations whatsoever to Plan participants.[115] Moreover, Defendants SJHSRI, RWH and CCCB had already decided to put the Plan into receivership and ask for a severe cut in benefit payments to all Plan participants.[116]

An earlier internal draft of the April 13, 2016 PowerPoint presentation stated that the Plan was a "Church Plan" and, therefore, that the Plan participants' benefits were not protected under ERISA. However, as part of a long history of concealment from the Plan participants, and in order to continue to deceive Plan participants, this disclosure was deleted by Defendants Angell, SJHSRI, CCCB, and Prospect Chartercare, and did not appear in the presentation actually given. Indeed, the Plan participants were never informed that the Plan was purported to be a Church Plan, or that the Plan participants' benefits were not protected under ERISA.[117]

It was never "public knowledge," and Plan participants were never told that the Plan was being administered as a Church Plan, or that the Plan participants' benefits were not protected under ERISA, or that Defendants SJHSRI, RWH, and CCCB

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[114] FAC ¶ 315.

[115] FAC ¶ 316.

[116] FAC ¶ 316.

[117] FAC ¶ 317.

reserved the right not to make recommended contributions to the Plan, and in fact in many years did not make recommended contributions to the Plan.[118]

D. The Movant Defendants' Participation in the Unlawful Listing of SJHSRI in the Catholic Directory and the Diocesan Defendants' Misleading and Deceiving the Vatican and State Regulators to Approve the 2014 Asset Sale

The Movant Defendants participated in misrepresenting that there was a meaningful connection between SJHSRI and the Catholic Church after the 2014 Asset Sale, in order to wrongfully perpetuate the Plan's status as a "Church Plan" exempt from ERISA. In addition, and pursuant to the overall conspiracy and fraudulent scheme to defraud the Plan participants, the Diocesan Defendants misled and deceived the Vatican and state regulators to obtain approval for the 2014 Asset Sale.

1. Fraudulent Inclusion of SJHSRI in the Catholic Directory and Securing Vatican Approval for the 2014 Asset Sale

Although whether the Plan qualified for the church plan exemption from ERISA is not a subject of the motions to dismiss,[119] Plaintiffs' claims for fraudulent scheme and conspiracy are based in part on the actions taken and statements made by the Movant Defendants to fraudulently perpetuate that exemption. One of these actions concerned the fraudulent inclusion after 2014 of SJHSRI in the publication entitled the Official Catholic Directory ("Catholic Directory"), sometimes referred to as the Kennedy List, to enable SJHSRI to fraudulently claim church plan status.

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[118] FAC ¶ 318.

[119] It is, however, fully addressed in the Complaint. See FAC ¶¶ 57-113.

One of the requirements for church plan status for the Plan was that SJHSRI at all times was required to be a "qualified church-controlled organization" as defined in 29 U.S.C. § 1002 (33)(A)(ii), under which a church-controlled entity cannot be a "qualified church-controlled organization" unless it qualifies as a tax-exempt organization "under section 501 of Title 26." Plaintiffs allege for reasons set forth in the Complaint[120] that SJHSRI could not qualify as a tax exempt organization other than as a subordinate organization under the IRS approved group exemption for the United States Conference of Catholic Bishops ("U.S. Conference of Bishops").[121] The requirements for a subordinate organization to qualify under this group exemption include that the entity must be "operated, supervised, or controlled by or in connection with the Roman Catholic Church" in each year for which the exemption is claimed.[122]

Rather than requiring proof each year that a particular entity satisfies this requirement, the IRS accepts the listing of the entity in the Catholic Directory as *prima facie* proof of this qualification on a year-by-year basis.[123] The Catholic Directory contains diocesan entries, confirmed and approved by each diocese on an annual basis, for each subordinate organization that is "operated, supervised, or controlled by or in connection with the Roman Catholic Church," and entitled to exemption under the group ruling issued to the U.S. Conference of Bishops.[124]

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[120] FAC ¶¶ 99, 114.

[121] FAC ¶ 99.

[122] FAC ¶ 101.

[123] FAC ¶¶ 98, 102.

[124] FAC ¶ 103.

Defendants Corporation Sole, Diocesan Administration, and Diocesan Service were responsible to provide accurate and complete information to the Catholic Directory concerning subordinate organizations in the Diocese of Providence that are "operated, supervised, or controlled by or in connection with the Roman Catholic Church" that claim exemption under the group ruling issued to the U.S. Conference of Bishops.[125]

At all relevant times before 2015, Defendants Corporation Sole, Diocesan Administration, and Diocesan Service listed SJHSRI in the Catholic Directory as a subordinate organization that was "operated, supervised, or controlled by or in connection with the Roman Catholic Church" in the Diocese of Providence, as a "hospital."[126] In and since 2015, Defendants Corporation Sole, Diocesan Administration, and Diocesan Service listed SJHSRI in the Catholic Directory as a subordinate organization that was "operated, supervised, or controlled by or in connection with the Roman Catholic Church" in the Diocese of Providence, as a "miscellaneous" entity.[127]

At least since the 2014 Asset Sale, which included the transfer of all of SJHSRI's operating assets, SJHSRI was not "operated, supervised, or controlled by or in connection with the Roman Catholic Church," either in the Diocese of Providence or anywhere else.[128] Accordingly, SJHSRI was no longer entitled to come under the group exemption issued to the U.S. Conference of Bishops, and pursuant to federal law should have been deleted and removed from the Catholic Directory by Defendants

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[125] FAC ¶ 104.
[126] FAC ¶ 109.
[127] FAC ¶ 110.
[128] FAC ¶ 111.

Corporation Sole, Diocesan Administration, and Diocesan Service, effective on June 20, 2014, when the closing of the Asset Sale occurred, or at least prior to the issuance of the 2015 Catholic Directory.[129]

At all relevant times, Defendants SJHSRI, CCCB, RWH, CC Foundation, Corporation Sole, Diocesan Administration, Diocesan Service, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, Prospect East, and Angell, knew that if the Plan ceased to qualify as a Church Plan, it would become subject to ERISA.[130]

On March 18, 2013, Defendant Prospect Medical signed a Letter of Intent that proposed a joint venture to operate Fatima Hospital and Roger Williams Hospital with Defendant CCCB, that involved Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical and Prospect East paying off SJHSRI's and RWH's bonded indebtedness of approximately $31,000,000, paying $14,000,000 into the Plan, committing $50,000,000 over four years for capital projects and network development, and funding annual asset depreciation in the amount of $10,000,000.[131]

However, the $14,000,000 contribution to the Plan would only reduce SJHSRI's unfunded liabilities for the Plan to approximately $59,000,000. The Letter of Intent stipulated that liability for the Plan would remain with SJHSRI, and, therefore, that Fatima Hospital under the operation of its new owners would be relieved of these unfunded liabilities. Accordingly, the parties had to determine if there was a way that they could make it appear lawful for SJHSRI to retain that liability and Prospect

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[129] FAC ¶ 112.

[130] FAC ¶ 114.

[131] FAC ¶ 124.

Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East to avoid that liability.[132]

Prior to Prospect Medical signing the letter of intent, LHP Hospital Group, Inc. ("LHP"), a for-profit corporation that operated five hospitals outside of Rhode Island, had submitted a letter of intent to CCCB, SJHSRI, and RWH.[133] The letter of intent proposed a joint venture, under which LHP would pay $33,000,000 to pay off SJHSRI and RWH's bonded indebtedness, pay an additional $72,000,000 to fund the Plan, and commit an additional approximately $50,000,000 for future capital improvements and network expansion.[134] The $72,000,000 figure was based upon Defendant Angell's estimate that the unfunded status of the Plan in 2011 was $72,000,000.[135]

The Trustees and executive management of SJHSRI, CCCB, and RWH did not favor LHP's insistence on applying so much capital to pay off the unfunded pension liability.[136] They wanted to allocate more of the purchase money for other purposes, instead of fulfilling their obligations to the Plan participants by choosing a buyer or joint-venturer who would adequately fund the Plan.[137] Accordingly, they determined to proceed under the letter of intent from Prospect Medical.[138]

Defendant Prospect Medical, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect East, SJHSRI, CCCB, RWH, Corporation Sole, Diocesan

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[132] FAC ¶ 125.

[133] FAC ¶¶ 119-20.

[134] FAC ¶ 120.

[135] FAC ¶ 121.

[136] FAC ¶ 122.

[137] FAC ¶ 122.

[138] FAC ¶¶ 123-24.

Administration, and Diocesan Service knew that if the Plan ceased to qualify as a Church Plan, it would become subject to ERISA, and, in that event, a company that took over the operations of Fatima Hospital would have successor liability for the Plan.[139]

Accordingly, Prospect Medical Holding's proposal was conditioned upon the transaction being structured to make it appear lawful for liability for the Plan to remain with SJHSRI and for it to continue to be claimed to be a Church Plan, to avoid the imposition of successor liability.[140] That condition required the cooperation of Corporation Sole, Diocesan Administration, and Diocesan Service in continuing to allow SJHSRI to claim tax exempt status under the group ruling issued to the U.S. Conference of Bishops, by continuing to list SJHSRI in the Catholic Directory.[141]

SJHSRI had other options that would have fully funded the Plan. One option was the outright sale of the hospital, for which SJHSRI would have received a purchase price sufficient to fund the Plan.[142] However, that conflicted with the goals of the board of trustees and executive management of SJHSRI, CCCB, and RWH of retaining as much "local control" of the hospitals as possible and keeping existing management in place.[143] Another option was to affiliate with a company such as LHP that was willing to fully fund the Plan. However, that conflicted with the goals of the board of trustees and

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[139] FAC ¶¶ 126-27.

[140] FAC ¶ 128.

[141] FAC ¶ 129.

[142] FAC ¶ 130.

[143] FAC ¶ 131.

executive management of SJHSRI, CCCB, and RWH to allocate more of the purchase price to other purposes.[144]

Expressing concern over committing to the asset sale with Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East without this issue being resolved, CCCB's Chief Executive Officer Kenneth Belcher at a meeting of the Executive Committee of CCCB's Board of Trustees on July 25, 2013 raised the possibility of signing an asset sale agreement with the Prospect Entities but making it "'subject to' if Bishop signs off on the pension piece."[145] The conclusion of this meeting of the Executive Committee was to share the current version of the asset purchase agreement ("APA") with Bishop Tobin, Corporation Sole, Diocesan Administration, and Diocesan Service, and seek their support and agreement to maintaining SJHSRI in the Catholic Directory, prior to SJHSRI, RWH, and CCCB signing the Asset Purchase Agreement.[146]

On August 14, 2013, counsel for SJHSRI, CCCB, and RWH (including at least Keith Anderson), together with CCCB "senior leadership" (including at least Kenneth Belcher and Edwin Santos) met at the offices of Corporation Sole, Diocesan Administration, and Diocesan Service to obtain their cooperation.[147] That meeting was also attended by Bishop Tobin, Rev. Timothy Reilly (the Chancellor of the Diocese of Providence), and Msgr. Paul Theroux (who was a member of the Diocesan Finance Council). Bishop Tobin, Rev. Reilly, and Msgr. Theroux attended and participated in the

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[144] FAC ¶ 132.
[145] FAC ¶ 139.
[146] FAC ¶ 140.
[147] FAC ¶ 141.

meeting on behalf of Defendants Corporation Sole, Diocesan Administration, and Diocesan Service.[148]

Counsel for SJHSRI, CCCB, and RWH (including at least Keith Anderson) brought the current version of the Asset Purchase Agreement to the meeting. That draft (and the final version actually signed by the parties) provided for the sale of all of the operating assets of SJHSRI, including ownership of Fatima Hospital. It also included the requirement that SJHSRI would retain liability for the Plan, and that the new owners and operators of New Fatima Hospital would have no obligations to the Plan.[149]

Counsel for SJHSRI, CCCB, and RWH (including at least Keith Anderson) also brought to the meeting on August 14, 2013 with Bishop Tobin, Rev. Reilly, and Msgr. Theroux a document on the joint letterhead of counsel and CCCB, entitled "Overview of the Strategic Transaction with Prospect Medical Holdings, Inc., Presentation to the Board of Directors," referring to the Board of Trustees for SJHSRI, CCCB, and RWH.[150] Counsel for SJHSRI, CCCB, and RWH (including at least Keith Anderson) showed it to Bishop Tobin, Rev. Reilly, and Msgr. Theroux and went over it with them.[151]

That document outlined the salient details of the 2014 Asset Sale.[152] The very first page of the presentation noted that only $14 million of the sales proceeds would be paid into "the Church-sponsored retirement plan (the 'Church Plan')."[153]

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[148] FAC ¶ 141.
[149] FAC ¶ 142.
[150] FAC ¶ 143.
[151] FAC ¶ 144.
[152] FAC ¶ 145.
[153] FAC ¶ 147.

At this time, Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect Medical Holdings, Prospect East, Prospect SJHSRI, Prospect RWH, Corporation Sole, Diocesan Service, and Diocesan Administration knew that SJHSRI's unfunded liability for the Plan was approximately $73,000,000. Thus, they knew that the Asset Purchase Agreement contemplated leaving SJHSRI an unfunded liability for the Plan of approximately $59,000,000, and that SJHSRI would have no operating assets.[154]

The document then detailed certain promises that would be made to the Corporation Sole, Diocesan Administration, and Diocesan Service as part of the transaction, which were described as follows[155]:

> Catholic identity covenants of Prospect and Newco
>
> - Our Lady of Fatima Hospital and other legacy SJHSRI facilities will be operated in compliance with the ERDs[[156]]
> - Roger Williams Medical Center and its facilities will not engage in prohibited activities
>   - Abortion
>   - Euthanasia
>   - Physician-assisted suicide
> - Any hospital or facility acquired or established after Closing must comply with restrictions on prohibited activities
> - The Bishop has a direct right to enforce the Catholicity covenants
> - CCHP intends to propose that the Bishop may require a name change of Our Lady of Fatima Hospital and other

[154] FAC ¶ 148.

[155] FAC ¶ 149.

[156] Ethical and Religious Directives for Catholic Health Care Services. See FAC ¶ 149.

legacy SJHSRI facilities if he is unsuccessful in enforcing the covenants

These "Catholic identity covenants" included essentially all the rights which Corporation Sole, Diocesan Administration, and Diocesan Service, and the Diocese of Providence, were entitled to exercise over Old Fatima Hospital and Old Roger Williams Hospital, SJHSRI, and RWH, since 2009 when SJHSRI and RWH became part of CCCB.[157] Thus, notwithstanding the 2014 Asset Sale, Corporation Sole, Diocesan Administration, and Diocesan Service were offered the promise that New Fatima Hospital and New Roger Williams Hospital would remain as Catholic as Old Fatima Hospital and Old Roger Williams Hospital had been before the asset sale.[158]

Defendants Corporation Sole, Diocesan Administration, and Diocesan Service believed that Fatima Hospital would fail unless it was relieved of its pension liabilities, which concerned them because it would mean "that a consistent Catholic healthcare presence in the Diocese of Providence would be gravely compromised."[159]

In other words, the "deal" they were offered was that Defendants Corporation Sole, Diocesan Administration, and Diocesan Service would transfer to the new hospitals the "Catholicity" and associated controls that they had previously enjoyed over Old Fatima Hospital, Old Roger Williams Hospital, SJHSRI, and RWH, and New Fatima Hospital would be freed from the unfunded liabilities of the Plan, at the expense of the Plan and the Plan participants.[160]

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[157] FAC ¶ 150.

[158] FAC ¶ 150.

[159] FAC ¶ 172.

[160] FAC ¶ 151.

This "Overview of the Strategic Transaction" that counsel reviewed with Bishop Tobin, Rev. Reilly, and Msgr. Theroux during the meeting on August 14, 2013, then laid out the *quid pro quo* for freeing New Fatima Hospital from the unfunded liabilities of the Plan, and granting these extensive and perpetual "Catholic identity covenants" for New Fatima Hospital and New Roger Williams Hospital.[161] Defendants SJHSRI, RWH, and CCCB, through their counsel, informed Bishop Tobin, Rev. Reilly, and Msgr. Theroux at this meeting that it was a "requirement" of the parties to the Asset Purchase Agreement that Defendants Corporation Sole, Diocesan Administration, and Diocesan Service "[m]aintain the retirement plan of St. Joseph Health Services of Rhode Island as a 'Church Plan'."[162]

As further discussed below, SJHSRI's only "Catholic" attribute was through its operation of Fatima Hospital. Thus, Defendants Corporation Sole, Diocesan Administration, and Diocesan Service knew that by agreeing to the proposed asset sale they were giving up any control over, association, or connection with SJHSRI.[163] All of the attendees at this meeting understood that continuing to list SJHSRI in the Catholic Directory would be a misrepresentation, and an unlawful evasion of tax law and ERISA, because Defendants Corporation Sole, Diocesan Administration, Diocesan Service would not control or be associated with SJHSRI after the closing of the 2014 Asset Sale.[164]

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[161] FAC ¶ 153.

[162] FAC ¶ 153.

[163] FAC ¶ 156.

[164] FAC ¶ 158.

At this meeting on August 14, 2013 (and again on several later occasions as discussed below), Defendants Corporation Sole, Diocesan Administration, and Diocesan Service agreed to continue to list SJHSRI in the Catholic Directory.[165]

On September 11, 2013, the Diocesan Chancellor Msg. Reilly contacted counsel for SJHSRI, CCCB, and RWH (Keith Anderson) and stated that the "our Diocesan Finance Council and College of Consultors also need to consent to the act of alienation," and asked counsel (Keith Anderson) to provide them with the Overview of the Strategic Transaction that counsel (Keith Anderson) had shared with Defendants Corporation Sole, Diocesan Administration, and Diocesan Service on August 14, 2013, because "[t]he Bishop thinks it would be a concise and helpful overview for the council members."[166] The next day counsel sent it to the Chancellor, addressing the document as "[f]or the Bishop of the Roman Catholic Diocese of Providence, Rhode Island." The document set forth exactly the same bargain.[167]

On September 17, 2013 the Diocesan Finance Council and College of Consultors met to decide whether to vote in favor of alienation of the assets of SJHSRI pursuant to the proposed asset sale. Bishop Tobin, Chancellor Reilly, and Monseigneur Theroux attended as members of both, with Bishop Tobin as Chairman. Bishop Tobin also acted in his capacity as President of Corporation Sole, Diocesan Administration, and Diocesan Service.[168] The Diocesan Finance Council and the College of Consultors

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[165] FAC ¶ 159.

[166] FAC ¶ 164.

[167] FAC ¶ 165.

[168] FAC ¶ 166.

approved the transaction.[169] Defendants Corporation Sole, Diocesan Administration, and Diocesan Service controlled the Diocesan Finance Council and the College of Consultors, and knew that such approval was both improper and unlawful.[170]

Vatican approval of the transaction was required for Corporation Sole, Diocesan Administration, and Diocesan Service to agree to the 2014 Asset Sale.[171] Defendants SJHSRI, RWH, CCCB, Corporation Sole, Diocesan Administration, and Diocesan Service all understood that the Vatican must approve specifically the "pension restructuring."[172] On September 18, 2013, Chancellor Reilly provided counsel for SJHSRI, CCCB, and RWH (including at least Keith Anderson) with a draft of Bishop Tobin's proposed letter to the Secretary of the Congregation for the Clergy in Rome requesting approval for the 2014 Asset Sale, and sought counsel's "comments/suggestions" concerning the letter.[173] Bishop Tobin's draft letter to the Vatican purported to summarize the transaction. It recounted the "merger" of SJHSRI and RWH into CCCB in 2009, and stated that "[s]hortly thereafter, in the wake of the global economic downturn, CharterCARE soon began to experience the need for increased capital and was confronted with a **spiraling and gaping unfunded liability within its employee-pension system**" (emphasis supplied). The draft noted that the

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[169] FAC ¶ 169.
[170] FAC ¶ 169.
[171] FAC ¶ 139.
[172] FAC ¶ 180.
[173] FAC ¶ 170.

proposed sale would apply "approximately $14 million to fund the Church-sponsored employee pension plan."[174]

Bishop Tobin then stated that "without [approval of] this transaction, it appears that a consistent Catholic healthcare presence in the Diocese of Providence would be gravely compromised, and the financial future for employees-beneficiaries of the pension plan would be at significant risk. I believe that the APA [Asset Purchase Agreement] between CharterCARE and Prospect will help avoid the catastrophic implications of such a failure, and at the same time, enhance the quality of care at SJHSRI/Our Lady of Fatima."[175]

The draft letter did not refer to or otherwise disclose Defendants Corporation Sole, Diocesan Administration, and Diocesan Service's undertaking to "[m]aintain the retirement plan of St. Joseph Health Services of Rhode Island as a 'Church Plan'," which would have been impossible to justify given that SJHSRI would no longer operate as a hospital or have any connection to the Diocese of Providence or Defendants Corporation Sole, Diocesan Administration, and Diocesan Service.[176]

Counsel for SJHSRI, CCCB, and RWH (Keith Anderson) revised the draft by *deleting* the reference to "spiraling and gaping" liability, and substituted "significant" liability, stating that he preferred the revision "**in the event this letter was ever subject to discovery in a civil lawsuit**" (emphasis added).[177] Counsel for SJHSRI, CCCB, and

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[174] FAC ¶ 171.
[175] FAC ¶ 172.
[176] FAC ¶ 174.
[177] FAC ¶ 175.

RWH (Keith Anderson) left untouched, however, all of the other statements quoted above.[178]

Defendants Corporation Sole, Diocesan Administration, Diocesan Service, SJHSRI, RWH, and CCCB knew that these statements were at best misleading if not simply false. They knew that even after the $14 million contribution, the Plan would remain seriously underfunded, and the financial future of the pensioners would be at much more than merely "significant risk." They knew that approval of the alienation would not avoid the "catastrophic implications" of that failure. To the contrary, they knew that such approval would increase the risk of such failure by depriving SJHSRI of operating income it needed to meet its obligations under the Plan, and hindering if not completely frustrating the Plan participants' rights to demand contributions by or recover damages from an asset-holding and income-generating hospital.[179]

Bishop Tobin did not disclose in his letter to the Vatican that the proposed asset sale increased the probability of the Plan failing. Instead Bishop Tobin, intentionally and with intent to deceive, omitted that information and, in effect, said the opposite, that approval of the asset sale was actually necessary to secure the Plan.[180]

On September 27, 2013, Bishop Tobin signed his letter as altered by counsel for SJHSRI, CCCB, and RWH and sent it to the Vatican. In so doing, Bishop Tobin acted individually and in his capacity as President of Defendants Corporation Sole, Diocesan Administration, and Diocesan Service. He also acted in furtherance of the conspiracy

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[178] FAC ¶ 176.

[179] FAC ¶ 177.

[180] FAC ¶ 178.

that included those entities and Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, Prospect East, and Angell.[181]

Vatican approval was obtained in early 2014, along with other necessary approvals, and the asset sale closed on June 20, 2014.[182] In conformity with the "strategic plan" to which Defendants SJHSRI, CCCB, RWH, Corporation Sole, Diocesan Administration, and Diocesan Service had agreed prior to the closing of the asset sale, SJHSRI was not deleted from the 2014 Catholic Directory immediately after the 2014 Asset Sale, although it should have been.[183]

As the next step in that plan, counsel for SJHSRI, CCCB, and RWH contacted the Diocese in late 2014 to ensure that SJHSRI would be included in the Catholic Directory for the coming year, 2015.[184] However, on November 11, 2014, Diocesan Chancellor Reilly e-mailed one or more representatives of Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East (including at least Otis Brown) and admitted that "Fatima and SJHSRI are not eligible for listing at this time."[185] He noted that "[r]ecently, the USCCB has instituted more formalized and rigorous policies and procedures, with increased expectations for the local Dioceses, in light of stricter IRS scrutiny of group rulings."[186] Moreover, the Chancellor observed that it was not a matter that could be handled

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[181] FAC ¶ 179.
[182] FAC ¶ 182.
[183] FAC ¶ 183.
[184] FAC ¶ 184.
[185] FAC ¶ 185.
[186] FAC ¶ 185.

discreetly out of public view.[187] Notwithstanding that the Prospect Entities purported to have no liability for the Plan, the response of their representative (Otis Brown) was to e-mail Chancellor Reilly and Monsignor Theroux on December 2, 2014, with copies to SJHSRI and CCCB, stating that if SJHSRI were not listed in the Catholic Directory, that would "mean that the SJHS[RI] pension would no longer be treated as a church plan."[188]

On December 23, 2014, counsel for SJHSRI (Hans Lundsten) sent an e-mail to counsel for Corporation Sole, Diocesan Administration, and Diocesan Service, which he copied to representatives of Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East (including at least Otis Brown) and Angell, that reminded everyone of the consequences of Corporation Sole, Diocesan Administration, and Diocesan Service not listing SJHSRI in the Catholic Directory:

> SJHSRI believes that if it is not included in the 2015 issue of the directory that the pension plan will no longer qualify as a church plan and that **the loss of that status will require that they immediately notify the applicable governmental authorities that the plan is currently underfunded**.[189]
>
> [Emphasis supplied]

In response, and to avoid that disclosure to governmental authorities, Corporation Sole, Diocesan Administration, and Diocesan Service on December 31, 2014 again improperly agreed that SJHSRI would remain in the Catholic Directory for 2015, under the continuing "sponsorship" of the Diocese of Providence. On or about January 1, 2015, Corporation Sole, Diocesan Administration, and Diocesan Service

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[187] FAC ¶ 185.

[188] FAC ¶ 186.

[189] FAC ¶ 188.

contacted the editors of the Catholic Directory and saw to it that SJHSRI remained listed in the Catholic Directory for 2015, under the "miscellaneous" activities of the Diocese of Providence. That listing was repeated in the 2016 and 2017 editions of the Catholic Directory, the latter being the most recent edition as of June 2018.

The IRS should have been notified but was never informed that SJHSRI no longer was entitled to tax exempt status under the group ruling the IRS issued to the U.S. Conference of Bishops. SJHSRI thereafter continued to file informational nonprofit organization returns to the IRS that it was no longer entitled to file and failed to file income tax returns that it was required to file.[190] Specifically, Defendant SJHSRI on or about August 16, 2016, filed with the IRS a "Return of Organization Exempt From Tax," Form 990, that falsely claimed that SJHSRI had tax exempt status under 26 U.S.C. § 501(c)(3) for the tax year from October 1, 2014 through September 30, 2015.[191] Defendant SJHSRI on or about August 10, 2017, filed with the IRS a "Return of Organization Exempt From Tax," Form 990, that falsely claimed that SJHSRI had tax exempt status under 26 U.S.C. § 501(c)(3) for the tax year from October 1, 2015 through September 30, 2016.[192]

Corporation Sole, Diocesan Administration, and Diocesan Service knew that their agreeing to continue to list SJHSRI in the Catholic Directory would enable Defendant SJHSRI to file these false returns, and knew and expected that Defendant SJHSRI in fact would file these false returns.[193] These false claims were material in that they

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[190] FAC ¶ 195.

[191] FAC ¶ 196.

[192] FAC ¶ 197.

[193] FAC ¶ 198.

hindered or had the potential for hindering the IRS's efforts to monitor and verify Defendant SJHSRI's tax liability.

Corporation Sole, Diocesan Administration, and Diocesan Service chose to prefer their interest in having New Fatima Hospital operated under the Catholic identity covenants, and having New Fatima Hospital freed of approximately $59,000,000 in liabilities, over the interests of the Plan participants in their hard-earned pensions.[194]

Another inducement for Corporation Sole, Diocesan Administration, and Diocesan Service improperly agreeing to retain SJHSRI in the Catholic Directory was that if the asset sale went forward, Corporation Sole, Diocesan Administration, and Diocesan Service would receive nearly $640,000 in repayment of a loan from the Inter-Parish Loan Fund.[195] That concerned improvements by SJHSRI to a property that Corporation Sole, Diocesan Administration, and Diocesan Service continued to own after the 2014 Asset Sale, and which had benefitted from the improvements.[196] In connection with the 2014 Asset Sale, the Inter-Parish Loan Fund received proceeds of $638,838.25 from the proceeds of the sale of SJHSRI's assets.[197] On August 22, 2014, Bishop Tobin directed that $100,000 of this amount be transferred to the Priests' Retirement Fund instead of the SJHSRI Plan, thereby favoring priests over Plan participants, and that the balance be applied towards a Diocesan Line of Credit.[198]

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[194] FAC ¶ 204.
[195] FAC ¶ 206.
[196] FAC ¶ 207.
[197] FAC ¶ 209.
[198] FAC ¶ 210.

2. The Diocesan Defendants' Deception of State Regulators to Secure Approval for the 2014 Asset Sale

On February 14, 2014, pursuant to the conspiracy in which Corporation Sole, Diocesan Administration, and Diocesan Service were participating with Defendants SJHSRI, RWH, CCCB, and Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East to relieve Fatima Hospital of any liability under the Plan at the expense of the Plan participants, Bishop Tobin (acting individually and as President of Corporation Sole, Diocesan Administration, and Diocesan Service) personally wrote to the Health Services Council to lobby in favor of regulatory approval of the for-profit hospital conversion:

> I write on behalf of the proposed partnership between CharterCARE Health Partners and Prospect Medical Holdings. . . .
>
> * * *
>
> The Diocese of Providence is grateful to CharterCARE for all it has done to preserve the healing ministry of SJHSRI/Our Lady of Fatima Hospital, all within very difficult financial circumstances. However, without this transaction, it appears that a consistent Catholic health care presence in the Diocese of Providence would be gravely compromised, **and the financial future for employee-beneficiaries of the pension plan would be at a significant risk. I believe that this partnership will help avoid the catastrophic implications of such a failure**, and at the same time, enhance the quality of care at SJHSRI/Our Lady of Fatima.[199]
>
> [Emphasis added]

However, as explained above, rather than believing the 2014 Asset Sale would help avoid pension failure, Bishop Tobin personally, and, through him and other officials, Defendants Corporation Sole, Diocesan Administration, and Diocesan Service,

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[199] FAC ¶ 320.

knew that “the proposed partnership between CharterCARE Health Partners and Prospect Medical Holdings” made pension failure much more likely, and, indeed, a virtual certainty, absent unanticipated and extremely improbable investment gains, because it would cut the link between the Plan and an operating hospital, and would transfer assets from SJHSRI that otherwise would be available to help fund the Plan.[200]

E. The Prospect Entities’ and Angell’s Participation in the Fraudulent Scheme and Conspiracy

In additional to making intentional misrepresentations to Plan participants and their role in insisting on the fraudulent inclusion of SJHSRI in the Catholic Directory, the primary direct contributions of the Prospect Entities to the conspiracy and fraudulent scheme against the Plan and the Plan participants involved the Prospect Entities’ actions and statements to union representatives and state regulators, whose approval was necessary to accomplish the goal of the conspiracy and the scheme of protecting the assets of Fatima and Roger Williams Hospital from pension liabilities, and transferring those assets to the Prospect Entities and to SJHSRI and RWH’s controlling member, CCCB. In additional to making intentional misrepresentations to Plan participants, Angell’s primary direct contribution involved preparation of calculations submitted to union representatives and state regulators which were false and misleading and contained material omissions that Angell had a duty to disclose.

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[200] FAC ¶ 321.

1. Misleading UNAP

Many of SJHSRI's employees were members of the United Nurses & Allied Professionals ("UNAP"), under a collective bargaining agreement that entitled them to pension benefits.[201] In connection with the 2014 Asset Sale, Defendants SJHSRI, RWH, CCCB, Angell, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East sought UNAP's agreement to a freeze on the accrual of pension benefits upon the closing of the asset sale.[202] In these negotiations, these Defendants knew and understood that UNAP was acting on behalf of the Plan participants who belonged to the union.[203]

Beginning in August 2013 and continuing thereafter, Christopher Callaci of UNAP had discussions with representatives from Prospect Medical, including Thomas Reardon and Von Crockett, regarding the potential acquisition by Prospect Medical or its subsidiaries of the Fatima and Roger Williams Hospitals and the impact of such acquisition on UNAP's members.[204] In those discussions, Mr. Callaci was told that if the acquisition transaction closed, $14 million would be paid into the Plan in connection with the closing, and thereafter CCCB and its subsidiaries would make the annual actuarially recommended contributions to the Pension Plan.[205] In connection with these meetings, Mr. Callaci was given a calculation prepared by Angell that represented that

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[201] FAC ¶ 297.

[202] FAC ¶ 297.

[203] FAC ¶ 297.

[204] FAC ¶ 298.

[205] FAC ¶ 299.

even as of July 1, 2032, the Pension Fund would remain more than 70% funded under that promise.[206]

At the same time, a second calculation was prepared by Angell for internal use by SJHSRI, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, which showed the impact on the Plan from not making those annual contributions in the future, which showed that the Pension Fund would be 0% funded by July 1, 2032.[207] Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew that was the scenario SJHSRI actually intended to follow.[208]

2. Misleading State Regulators

In 2014 Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, with the support of Defendant Angell, sought and obtained approval from the Rhode Island Department of Health and the Rhode Island Attorney General to convert Fatima Hospital and Rogers Williams Hospital into for-profit operations, pursuant to a common application.[209]

On April 9, 2014, CCCB provided Angell with a document prepared by the Rhode Island Attorney General's office, consisting of questions to be answered in connection

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206 FAC ¶ 301.

207 FAC ¶ 302.

208 FAC ¶ 302.

209 FAC ¶ 319.

with that application, and asked for Angell's assistance in answering the following question:

> Please provide:
>
> * * *
>
> b. documentation as to the determination that $14 m will stabilize the plan and a description and any written information of the understanding with employee representatives with respect to the freezing and the funding of the plan;[210]

Previously, on December 20, 2013, Brian Corbett of Angell had provided CCCB and SJHSRI (through Darlene Souza and Michael Conklin) with calculations which demonstrated that if $14,000,000 was contributed to the Plan, and assuming a future rate of return of 7.75%, the Plan would run out of funds in 2034, at a time when it would still have over $99 million in unpayable liabilities to Plan participants.[211] Angell authorized the recipients to share the calculations with "Ken Belcher and any other party who would benefit from this analysis."[212]

On March 27, 2014, Angell updated its calculations based on a slightly higher value of the Plan assets at the beginning of 2014, which projected that even with the $14,000,000 contribution, the Plan would run out of funds in 2036, at a time when it would still have over $98 million in liabilities to Plan participants.[213] To illustrate the consequences if the 7.75% rate of return proved to be too high, Angell also provided an alternative calculation, in which Angell assumed a lower rate of return of 5.75% rather

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[210] FAC ¶ 324(b).

[211] FAC ¶ 325.

[212] FAC ¶ 325.

[213] FAC ¶ 326.

that 7.75%, under which the Plan would run out of assets six years earlier, in 2030, with additional unpayable liabilities to Plan participants.[214]

Indeed, if the 5.75% rate of return were utilized, the Plan would have been only 66% funded in 2014 even with the contribution of $14,000,000.[215] The market discount rate in early 2014 that single employer benefit plans were required to use under ERISA was 4.6%, which if utilized would have produced an even lower funding level.[216]

On April 7, 2014, Darlene Souza on behalf of SJHSRI, RWH, and CCCB, informed Barbara Groux of Prospect Medical Holdings that following their meeting with Angell on January 8, 2014, she had obtained Angell's calculations showing that if $14 million was contributed to the Plan in 2014 but there were no subsequent contributions, the Plan would run out of money in 2036, even if the Plan investments earned a 7.75% annual return throughout that period.[217]

On April 10, 2014, however, CCCB and SJHSRI through Brenda Ketner asked Angell to modify that calculation for submission to the Attorney General and the Department of Health. The requested modification was that Angell utilize only the higher projected rate of return of 7.75%, delete all the calculations post-2014, and "simply show only the stabilization effect [in 2014] of the incoming $14M to the plan with no other information shown."[218]

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[214] FAC ¶ 326.
[215] FAC ¶ 327.
[216] FAC ¶ 328.
[217] FAC ¶ 329.
[218] FAC ¶ 330.

An employee of Angell (Brian Corbett) spoke to the CCCB representative who had requested the modification, and was told that CCCB "wants to show the projection of the funded status after the $14M contribution for 2014," in order to "highlight the 'stabilization' of the Plan." That employee passed this information on to other Angell employees (at least David Ward, Albert Krayter, and Sonja Baron).[219]

Angell (through at least these named employees) knew it was thereby being asked to present the 2014 funding level in isolation, for purposes of demonstrating Plan stabilization to the Attorney General and the Department of Health. Angell also knew (through at least these named employees) that such a presentation would be false and misleading, because the complete calculation demonstrated that the $14,000,000 contribution would *not* "stabilize" the Plan, since the complete calculation showed that, notwithstanding that contribution, the Plan would run out of money in 2036 with over $98,000,000 in liabilities to Plan participants even at the high assumed rate of return of 7.75%, or in 2030 with the rate of return of 5.75%.[220]

Angell (through at least these named employees) agreed to disregard both of its prior calculations and on April 11, 2014, provided SJHSRI, RWH, and CCCB with the requested new calculation, knowing and intending they would give the calculation to the Rhode Island Department of Health and the Rhode Island Attorney General in support of the application for approval of the asset sale, which was done on or about April 14, 2018.[221]

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[219] FAC ¶ 331.

[220] FAC ¶ 332.

[221] FAC ¶ 333.

Prior to providing it to the Rhode Island Department of Health and the Rhode Island Attorney General, Defendants SJHSRI, CCCB, and RWH shared that calculation with Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East and informed them it would be delivered to the Rhode Island Department of Health and the Rhode Island Attorney General on behalf of Defendants SJHSRI, CCCB, RWH, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East.[222]

That new calculation purported to show that the immediate effect of the $14 million contribution would be to increase the funding percentage of the Plan to 94.9%, and deleted the calculations which demonstrated that the Plan nevertheless would run out of money in either 2030 or 2036 depending on what estimated rate of return was utilized. The submission of this new calculation with that deletion was grossly and intentionally deceptive.[223]

That calculation also did not disclose that the funding percentage of 94.9% was based on assumed investment returns that SJHSRI, RWH, CCCB, Angell, and Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew were nearly 70% above market rates of return (*i.e.*, Angell's projected rate of return of 7.75% was over 68% greater than the market rate of 4.6%).[224]

In addition, Defendants SJHSRI, RWH, CCCB, Angell, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew

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[222] FAC ¶ 333.

[223] FAC ¶ 333.

[224] FAC ¶ 334.

that the calculation did not disclose 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.[225]

These misrepresentations and omissions concerning the Plan's funding level were made with an intent to deceive and succeeded in deceiving both the Rhode Island Department of Health and the Rhode Island Attorney General into approving the asset sale, and to prevent SJHSRI's employee unions, the general public, and Plan participants from learning of the grossly underfunded status of the Plan.[226]

On February 21, 2014, the Department of Health sent a list of questions to counsel for SJHSRI, RWH, and CCCB, and to counsel for Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, Prospect East, and other subsidiaries of Prospect Medical Holdings.[227] On March 7, 2014, counsel for SJHSRI, RWH, and CCCB and counsel for Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, Prospect East, and other subsidiaries of Prospect Medical Holdings co-signed and sent the Department of Health a letter enclosing their clients' responses to the Department of Health's question.[228] Those responses were

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[225] FAC ¶ 335.

[226] FAC ¶ 336.

[227] FAC ¶ 339.

[228] FAC ¶ 339.

signed and attested to be "complete, accurate, and correct" by CCCB CEO Kenneth Belcher and Prospect Medical Holdings CEO Sam Lee, and repeated the question and responded, as follows:

> c. Please identify to what extent, if any, this purchase price will be used by CharterCARE for community benefit versus paying off debts.
>
> Response: The use of the sale proceeds as described is [sic] Section (b) above will benefit the community in three ways:
>
> * * *
>
> b. **The use of $14M to strengthen the St. Joseph Pension Plan will be of significant benefit to the community as it will assure that the pensions and retirement of many former employees, who reside in the community, are protected**.[229]
>
> [Emphasis supplied]

In fact, Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew this statement was false and misleading, and that the contribution of the $14,000,000 to the Plan would not "assure" that the benefits of the Plan participants were "protected", even according to the calculations that Angell shared with all of those other Defendants.[230]

On April 8, 2014, CCCB President and Chief Executive Officer Belcher testified at a public hearing held before the Project Review Committee of the Rhode Island Department of Health as part of the approval process.[231] He testified on behalf of all of the applicants for approval, including SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, at a

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[229] FAC ¶ 339(b).

[230] FAC ¶ 340.

[231] FAC ¶ 341.

time when he had already accepted the offer to act as the Chief Executive Officer of the new hospitals.[232] The meeting was also attended by Thomas Reardon on behalf of Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East.[233] Mr. Belcher was asked to address three questions raised by a recent report on SJHSRI by Moody's Investor Services.[234] The third question related to Moody's' concern over the funded status of employee retirement accounts, including the Plan.[235] Mr. Belcher testified as follows:

> MR. BELCHER: . . . But the third part was on the pension fund, and the impact on the pension fund with this -- and I think you know we shared information up-front is that at the time of the closing we'll be putting millions of dollars into the pension fund which will bring it to a level of roughly 91 and a half percent funding which is above the safe level that you need for sort of a quote safe level. So all of this really helps stabilize the pension fund as well.[236]

Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East thereby intentionally misled the state regulators by the statement that a funding level of 91.5% "is above the safe level," in order to obtain regulatory approval and to mislead Plan participants concerning the funded status of the Plan.[237] As discussed above, it is never proper to use a funding level on a single date to measure the health of a pension plan, but it especially inappropriate when the plan sponsor is selling all of its operating assets,

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[232] FAC ¶ 341.
[233] FAC ¶ 341.
[234] FAC ¶ 341.
[235] FAC ¶ 341.
[236] FAC ¶ 341.
[237] FAC ¶ 342.

because the plan sponsor will lack the means to make up the underfunding.[238] In that context, even if the projected rate of return of 7.75% were reasonable (which it was not), and were actually achieved over time, a funding level of 91.5% would practically guarantee pension plan failure, since it would denote insufficient funds to meet plan obligations even if all of the future assumptions upon which the funding level is based perform exactly as assumed, including thirty to forty years of investment returns.[239]

On April 11, 2014, Darlene Souza of CCCB reminded Brenda Ketner and Brenda Almeida of CCCB that the Attorney General was also asking Supplemental Question S3-48, as follows:

> S3-48 Will the pension liability remain in place – how much, and what is the plan going forward to fund the liability?[240]

Brenda Almeida immediately forwarded the reminder to David Ward and Peter Karlson of Angell, thereby keeping Angell informed of the role that the pension was playing in the approval process.[241]

On April 15, 2014, Defendant SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East responded to the Attorney General and answered that question as follows:

> Response: The pension liability will remain in place post transaction. Subsequent to the $14 Million contribution to the Plan upon transaction, **future contributions to the Plan will be made based on recommended annual contribution amounts as provided by the Plan's actuarial**

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[238] FAC ¶ 342.

[239] FAC ¶ 342.

[240] FAC ¶ 343.

[241] FAC ¶ 343.

> **advisors**. Moving forward, the investment portfolio of the plan will be monitored by the Investment Committee of the Board of Trustees.[242]
>
> [Emphasis supplied]

When that statement was made, however, Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew that it was the intention of SJHSRI, RWH, or CCCB *not* to make any future contributions, and, therefore, that "future contributions to the Plan" would *not* "be made based on recommended annual contribution amounts as provided by the Plan's actuarial advisors."[243]

Indeed, in spite of this representation, more than four years has passed since that statement was made and not a single penny has been contributed to the Plan other than the $14,000,000 contribution which they made to secure regulatory approval for the 2014 Asset Sale.[244]

On or about May 2, 2014, SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East submitted to the Attorney General another calculation that Angell had prepared which purported to show the effect on future pension liabilities of specific future annual contributions ranging from $600,000 to $1,390,000 made over the next thirty-five years.[245]

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[242] FAC ¶ 344.

[243] FAC ¶ 345.

[244] FAC ¶ 346

[245] FAC ¶ 347.

However, SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect RWH, Prospect Medical Holdings, and Prospect East knew that SJHSRI, RWH, and CCCB intended not to make those future annual contributions.[246] They also knew that the estimated future contributions ranging from $600,000 to $1,390,000 made over the next thirty-five years were not "recommended contributions" that would be sufficient to maintain Plan solvency, and that Angell had been instructed as to the amounts to be inserted, which were much less than Angell's actuarial "recommended contributions."[247] As a result, even if those estimated future contributions ranging from $600,000 to $1,390,000 were in fact made, they would be insufficient to fund the Plan past 2044, when the Plan would still have estimated liabilities of over $40,000,000, even if the Plan earned the assumed rate of return of 7.75%.[248] Indeed, at an estimated rate of return of 5.75%, the Plan would run out of money in 2032, with remaining liabilities of at least $80,000,000.[249]

The Project Review Committee held a public hearing on May 6, 2014.[250] During the testimony of the Department of Health's expert concerning the Plan, CCCB Chief Financial Officer Michael Conklin interrupted, and testified, on behalf of SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, that the "recommended contributions going forward" to fund the Plan were $600,000 per year, which he assured the Committee would be paid

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[246] FAC ¶ 348.
[247] FAC ¶ 349.
[248] FAC ¶ 349.
[249] FAC ¶ 349.
[250] FAC ¶ 350.

out of SJHSRI's expected $800,000 annual income from outside trusts, and profit sharing paid to CCCB in connection with its 15% share in Prospect Chartercare.[251] At this time Michael Conklin had already accepted the offer to act as the Chief Financial Officer for Prospect Chartercare and the new hospitals.[252]

Mr. Conklin, on behalf of SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, thereby misrepresented that SJHSRI's expected future income was $800,000, when in fact it was less than $200,000, and suggested that CCCB's profit-sharing in Prospect Chartercare would provide additional funds, when no profit sharing was anticipated for the indefinite future.[253] To date CCCB has yet to receive any profit sharing whatsoever.[254]

Mr. Conklin, on behalf of SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, also misrepresented that the projected annual contribution of $600,000 was an actuarial "recommended contribution," when in fact it was a number made up out of whole cloth by SJHSRI, RWH, and CCCB, and was much below the recommendations of the Plan actuary.[255]

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[251] FAC ¶ 350.

[252] FAC ¶ 350.

[253] FAC ¶ 351.

[254] FAC ¶ 351.

[255] FAC ¶ 352.

Mr. Conklin also did not disclose that SJHSRI, RWH, and CCCB had no intention of making any of those contributions.[256]

The Project Review Committee accepted these false assurances, but was aware that even those assurances were based upon assumed investment rates of return, and if the investment returns on Plan assets were lower than anticipated, higher annual contributions would be needed to make up the difference.[257] The Committee referred to this possibility as the "investment risk" of the Plan, and at the hearing on May 6, 2014 asked CCCB President and Chief Executive Officer Belcher "who's bearing the investment risk going forward?"[258] He replied on behalf of SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East as follows:

> MR. BELCHER: Heritage Hospitals [referring to SJHSRI and RWH]. It stays with the old CharterCare [referring to CCCB, SJHSRI, and RWH].
>
> MR. SGOUROS: Heritage Hospitals, and so if the investment returns don't match up to the predictions, who's on the hook?
>
> MR. BELCHER: The old hospitals, the old CharterCARE. We have that responsibility.[[259]]

As discussed above, in order to successfully deceive state regulators and Plan participants, Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East fraudulently

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[256] FAC ¶ 353.

[257] FAC ¶ 355.

[258] FAC ¶ 355.

[259] FAC ¶ 355.

misrepresented the intentions of SJHSRI, RWH, and CCCB, whom they knew never intended to support the Plan.[260]

In support of the contention that when this testimony was given, SJHSRI, RWH, and CCCB had already determined to attempt to evade future liability for the Plan, the Complaint alleges that on June 20, 2013, the CCCB Board discussed the possibility of seeking a "Special Master" for the Plan,[261] and in December 2013, the Executive Committee of the CCCB Board (the present board members included Edwin Santos, Sheri Smith, Joseph DiStefano, Daniel Ryan, Kenneth Belcher, and Donald McQueen), together with staff (including at least Kim O'Connell and Darleen Souza), discussed putting the Plan into receivership.[262]

Thus, notwithstanding the strategic delay in doing so, the scheme to abandon the Plan was already in the works when SJHSRI, RWH, and CCCB assured the Project Review Committee on April 8, 2014 and May 6, 2014 that the "recommended" annual contributions to the Plan would be made and that SJHSRI, RWH, and CCCB were "on the hook" if the projected returns on investment did not materialize.[263] In fact, in December 2014, soon after the closing of the asset sale, the board of trustees of RWH was replaced with individuals who were already planning to put the Plan into Receivership.[264]

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[260] FAC ¶ 355.

[261] FAC ¶ 367.

[262] FAC ¶ 368.

[263] FAC ¶ 369.

[264] FAC ¶ 361.

These public misrepresentations and material omissions were made on behalf of Defendants SJHSRI, CCCB, RWH, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East in order to fraudulently secure regulatory approval and to deceive Plan participants concerning the funded status of the Plan, and the state regulators and the Plan participants were in fact deceived.[265] Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East also chose to conceal the unfunded status of the Plan out of concern that such disclosure would be seized upon by a competitor that was asking the Department of Health to delay the proposed asset sale.[266] Indeed, at the same public hearing on May 6, 2014, a representative of that competitor strongly objected to the terms of the asset sale proposed by Defendants SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, and repeated his client's request that the Committee delay acting upon the application until his client's counter-proposal could be fully considered.[267]

The Attorney General did not immediately accept the assurances that there would be sufficient income following the asset sale to adequately fund the Plan. Instead, representatives of the Attorney General asked for proof of legal authority for RWH's assets to be used for that purpose.[268]

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[265] FAC ¶ 354.

[266] FAC ¶ 356.

[267] FAC ¶ 356.

[268] FAC ¶ 357.

On May 8, 2014 counsel for SJHSRI, RWH, and CCCB provided the Attorney General with a resolution purportedly approved by RWH's Board of Trustees stating, *inter alia*:

> WHEREAS As part of its retained assets, RWMC has $6,666,874 in Board Designated Funds ("the RWMC Board Designated Funds") that may be used for any purpose at the discretion and direction of the RWMC Board of Trustees;
>
> * * *
>
> RESOLVED The RWMC Board of Trustees approves and directs use of the RWMC Board Designated Funds to satisfy the SJHSRI liabilities at close and any potential future funding and expenses relating to the SJHSRI pension plan, and any surplus shall be transferred to the CCHP Foundation.[269]

They e-mailed a copy of the resolution to the Attorney General's office (with cc to counsel for Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East) and stated:

> Finally, attached is the Roger Williams Medical Center (RWMC) Board of Trustees Resolution authorizing the use of the RWMC Board Designated Funds to satisfy the St. Joseph Health Services of Rhode Island (SJHSRI) liabilities at close and any potential future funding and expenses related to the SJHSRI pension plan, and any surplus shall be transferred to the CCHP Foundation.[270]

However, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East knew that SJHSRI, RWH, and CCCB never intended that any part of RWH's "Board Designated Funds" would ever be contributed

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[269] FAC ¶ 358.

[270] FAC ¶ 359.

to the Plan, and, indeed, none have been.[271] They also knew that even $6,666,874 would be insufficient to meaningfully reduce the unfunded liability.[272]

Instead of meaning what it says, this resolution evidences SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East's willingness to tell regulators what they wanted to hear, even if it meant misrepresenting their intended funding sources and manipulating the board of trustees of affiliated companies.[273]

CCCB President and Chief Executive Officer Belcher and Thomas M. Reardon (president of Prospect Medical East) made a joint statement which the Providence Journal on May 12, 2014 published as an op-ed, which stated:

> The development and pursuit of innovation in health delivery should not come at the cost of one of the most cherished values in Rhode Island health care - that of local control. We are pleased that our proposal will assure preservation of local governance, as our joint venture board will have equal representation from CharterCare and Prospect with a local board chair, with real veto powers.[274]

This statement was materially false and intentionally deceptive, because under the Amended & Restated Limited Liability Company Agreement of Prospect Chartercare, LLC, previously agreed to in form by CCCB and Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, deadlocks between CCCB-appointed directors and Prospect-appointed directors for

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[271] FAC ¶ 360.

[272] FAC ¶ 360.

[273] FAC ¶ 361.

[274] FAC ¶ 371.

some of the most significant board-level decisions were to be resolved by allowing the decisions of Prospect-appointed board members to prevail.[275]

On the same day that Mr. Belcher's statement appeared in the Providence Journal, CCCB emailed it to all of the employees of CCCB, SJHSRI, and RWH, stating, "[w]e want to share the following op-ed that appeared in today's Providence Journal."[276] The same mailing assured all employees that "Prospect and CharterCARE equally share seats on the new company's eight-member governing board," withholding the critical information that although the number of seats were shared equally, the seats filled by Prospect East had the power to make some of the most significant corporate decisions against the wishes of the directors chosen by CCCB, and certainly without disclosing that the 2014 Asset Sale was merely a step in the scheme to shield Fatima Hospital from liability on the Plan, and to strip assets from SJHSRI that were needed to satisfy its pension obligations to those same employees.[277]

In addition to falsely reassuring the public and their own employees on the issue of local control, SJHSRI, RWH, CCCB, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East also misled state regulators concerning the degree of local control that CCCB would have after the 2014 Asset Sale.[278]

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[275] FAC ¶ 372.
[276] FAC ¶ 373.
[277] FAC ¶ 373.
[278] FAC ¶ 374.

On May 2, 2014, SJHSRI, RWH, CCCB and Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East, through their counsel, responded to the following question of the Rhode Island Attorney General:

> Question: Please describe the governance structure of the new hospital after conversion, including a description of how members of any board of directors, trustees or similar type group will be chosen.[279]

Defendants responded in pertinent part as follows:

> Response:
>
> An overview of the governance structure for Prospect CharterCARE, LLC is as follows:
>
> Prospect CharterCARE, LLC will have a Board of Directors.
>
> Prospect CharterCARE, LLC's Board of Directors will have half of its members selected by and through PMH's ownership in Prospect CharterCARE, LLC and the other half of the members will be selected by and through CCHP's ownership Prospect CharterCARE, LLC.
>
> The Board of Directors will be responsible for determining the patient Care, strategic, and financial goals policies and objectives of Prospect CharterCARE, LLC.
>
> * * *
>
> Prospect CharterCARE, LLC's Board of Directors will be structured as follows: (i) eight (8) members; (ii) fifty (50%) percent of its members will be appointed by PMH; and (iii) fifty (50%) percent of its members will be appointed by CCHP. The purpose of the structure is to ensure a strong local presence and mission. The Board of Directors will include at least one physician representative.
>
> The Board of Directors will be responsible for determining the patient care, strategic, and financial goals, policies and objectives of Prospect CharterCARE, LLC. **The issues that the Board of Directors will**

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[279] FAC ¶ 375.

> **address will require a majority vote of those Directors appointed by PMH, and a majority vote of those Directors appointed by CCHP.**[280]
>
> [Emphasis supplied]

The statement that "[t]he issues that the Board of Directors will address will require a majority vote of those Directors appointed by PMH, and a majority vote of those Directors appointed by CCHP" was also materially false, for the same reason that some of the most significant decisions were to be resolved by allowing Prospect-appointed board members' decisions to prevail.[281]

Even after the 2014 Asset Sale, Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East monitored the underfunded status of the Plan, by having consultants review Angell's actuarial reports and conduct their own actuarial analyses, which confirmed to Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East that if anything the Plan was becoming more underfunded.[282] For example, in early 2016, Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East had the Plan's funding status evaluated by BCG Pension Risk Consultants, Inc., who provided them with a report confirming that the plan remained grossly underfunded.[283]

Moreover, even after the 2014 Asset Sale, including at least on or about June 23, 2017, Defendants Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect

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[280] FAC ¶ 376.

[281] FAC ¶ 377.

[282] FAC ¶ 313.

[283] FAC ¶ 313.

Medical Holdings, and Prospect East, at least through their representative Von Crockett, communicated with Defendants SJHSRI, RWH, and CCCB, through those Defendants' representative Richard Land, and urged Defendants SJHSRI, RWH, and CCCB to take steps to terminate the Plan and deprive the Plan participants of pension benefits, such as by Defendants SJHSRI, RWH, and CCCB filing for bankruptcy, or by their placing the Plan into a state court receivership to obtain a court order significantly reducing the benefits of Plan participants.[284]

F. Fraudulent Transfers

1. The 2014 Asset Sale Was a Fraudulent Transfer

SJHSRI and RWH, not CCCB, owned the real estate and all of the assets used in operating Old Fatima Hospital and Old Roger Williams Hospital.[285] Thus, virtually all of the personal property and real property transferred in the 2014 Asset Sale was owned both historically and immediately prior to the sale by CCCB's various subsidiaries, primarily SJHSRI and RWH, and not by CCCB, such that virtually all of the actual consideration provided by the sellers came from SJHSRI and RWH, not from CCCB.[286]

The consideration that Prospect East provided at the closing on or about June 20, 2014 included 15% of the shares of Prospect Chartercare.[287] The fair market value of that 15% at the time of the asset sale was at least $6,640,000 according to Prospect

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[284] FAC ¶ 314.
[285] FAC ¶ 439.
[286] FAC ¶ 440.
[287] FAC ¶ 441.

Chartercare's own audited financials.[288] The Asset Purchase Agreement had provided that CCCB would receive those shares, as follows:

> Sellers have designated CCHP (the "Seller Member") to be the holder of the units representing the Company's limited liability company memberships on behalf of all Sellers to be issued as partial consideration in respect of the sale by Sellers of the Purchased Assets.[289]

The consideration that Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East provided in return for the assets included the undertaking to provide long term working capital of $50,000,000, and ordinary working capital of $10,000,000 per year, which conferred a benefit on CCCB as 15% shareholder in the additional amount of $9,479,000, according to Prospect Chartercare's own audited financials.[290]

Thus, notwithstanding that CCCB provided virtually none of the consideration for the transaction, the parties consummated the transaction so that CCCB obtained all of the 15% interest in Prospect Chartercare, totaling a fair market value of at least $15,919,000.[291] Although it was and should have been their property, SJHSRI and RWH kept none of that interest, and, therefore, that valuable asset was not available to satisfy claims of Plan participants, or any other creditors of SJHSRI.[292]

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[288] FAC ¶ 442.

[289] FAC ¶ 443.

[290] FAC ¶ 444.

[291] FAC ¶ 445.

[292] FAC ¶ 445.

2. The $8.2 Million Transferred Pursuant to the 2015 *Cy Pres* Proceeding Was a Fraudulent Transfer

The 2014 Asset Sale itself injured Plaintiffs in many ways, including that it attempted to insulate their employer and their employer's assets from liability under the Plan.[293]

Those injuries included the fraudulent transfer from Defendants SJHSRI and RWH to their related entity Defendant CC Foundation of approximately $8,200,000 that should have been deposited into the Plan.[294] This fraudulent scheme had two parts. First Defendants SJHSRI, RWH, CCCB, CC Foundation, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East conspired to persuade the Rhode Island Attorney General to disregard the mandatory requirements of the Hospital Conversions Act, and second, Defendants SJHSRI, RWH, and CC Foundation misled the Court into approving this transfer in the 2015 Cy Pres Proceedings as detailed below.[295]

R.I. Gen. Laws § 23-17.14-22 states on pertinent part as follows:

> § 23-17.14-22. Distribution of proceeds from acquisition – Selection and establishment of an independent foundation.
>
> (a) In the event of the approval of a hospital conversion involving a not-for-profit corporation and a for-profit corporation results in a new entity as provided for in § 23-17.14-7(c)(25)(i), it **shall be required** that the proceeds from the sale and any endowments, restricted, unrestricted and specific purpose funds shall be transferred to a charitable foundation operated by a board of directors.
>
> (b) The presiding justice of the superior court **shall have the authority** to:

[293] FAC ¶ 378.

[294] FAC ¶ 379.

[295] FAC ¶ 379.

> (1) Appoint the initial board of directors.
>
> (2) Approve, modify, or reject proposed bylaws and/or articles of incorporation provided by the transacting parties and/or the initial board of directors.

[Emphasis supplied]

However, Defendants SJHSRI, RWH, CCCB, CC Foundation, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East requested and the Rhode Island Attorney General agreed that this statute would be ignored, notwithstanding that its provisions are mandatory, such that failure to follow its provisions would violate the statute.[296] Defendants SJHSRI, RWH, CCCB, CC Foundation, Prospect Chartercare, Prospect SJHSRI, Prospect RWH, Prospect Medical Holdings, and Prospect East made that request because Defendants SJHSRI, RWH, CCCB, and CC Foundation wanted the money to go to CC Foundation, of which CCCB was the sole member, and not an "independent foundation," and wanted to name the board of directors for that foundation, instead of the directors being named by the Presiding Justice of the Superior Court.[297]

The result was that the Superior Court in the 2015 *Cy Pres* Proceeding was misled into permitting approximately $8,200,000 of SJHSRI's assets to be transferred to CC Foundation.[298]

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[296] FAC ¶ 381.

[297] FAC ¶ 381.

[298] FAC ¶ 405.

II. ARGUMENT

A. Plaintiffs Have Standing

1. The Elements of Statutory Standing

The issue of statutory standing depends on whether Plaintiffs have a cause of action under ERISA. See Bank of Am. Corp. v. City of Miami, Fla., 137 S. Ct. 1296, 1302 (2017) ("The question is whether the statute grants the plaintiff the cause of action that he asserts."). The question is not jurisdictional. Nw. Airlines, Inc. v. County of Kent, 510 U.S. 355, 365 (1994) ("The question whether a federal statute creates a claim for relief is not jurisdictional."). Accordingly, any objection to the Plaintiffs' statutory standing is not governed by Rule 12(b)(1), which concerns lack of subject matter jurisdiction, but, rather, by the standards applicable to motions filed under Rule 12(b)(6) for failure to state a claim.

Unlike constitutional standing, lack of statutory standing can be waived. See MHANY Mgmt. Inc. v. Inc. Vill. of Garden City, 985 F. Supp. 2d 390, 411 (E.D.N.Y. 2013) ("While the Garden City Defendants contested the standing of NYHAC and ACORN at the motion to dismiss stage, they couched their arguments in constitutional rather than statutory terms. Statutory standing arguments, unlike constitutional standing arguments, can be waived. Accordingly, the Court deems the Garden City Defendant's statutory standing arguments under Section 1982 to be waived."); Merrimon v. Unum Life Ins. Co. of America, 758 F.3d 46, 53 n.3 (1st Cir. 2014) (citations omitted) ("Statutory standing is, of course, different than constitutional standing. One way in which the two concepts differ is that arguments based on statutory standing, unlike arguments based on constitutional standing, are waivable.").

2. The Elements of Constitutional Standing

There are three elements to constitutional standing:

> To satisfy the Constitution's restriction of this Court's jurisdiction to "Cases" and "Controversies," Art. III, § 2, a plaintiff must demonstrate constitutional standing. To do so, the plaintiff must show an "injury in fact" that is "fairly traceable" to the defendant's conduct and "that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 578 U.S. ——, 136 S.Ct. 1540, 1547, 194 L.Ed.2d 635 (2016) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–561, 112 S. Ct. 2130, 119 L.Ed.2d 351 (1992)).

Bank of Am. Corp. v. City of Miami, Fla., *supra*, 137 S. Ct. at 1302. "To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" Spokeo, Inc. v. Robins, *supra*, 136 S. Ct. at 1548 (quoting Lujan v. Defenders of Wildlife, *supra*, 504 U.S. at 560). "This does not mean, however, that the **risk of real harm** cannot satisfy the requirement of concreteness." Id. (citation omitted and emphasis supplied).

Although the elements of Article III standing are constant throughout litigation, the standard used to establish these three elements is not constant but becomes gradually stricter as the parties proceed through the stages of the litigation. In re Deepwater Horizon, 739 F.3d 790, 800 (5th Cir. 2014) ("[T]the elements of Article III standing are constant throughout litigation: injury in fact, the injury's traceability to the defendant's conduct, and the potential for the injury to be redressed by the relief requested. As *Lujan* emphasized, however, the standard used to establish these three elements is not constant but becomes gradually stricter as the parties proceed through

"the successive stages of the litigation.") (quoting Lujan v. Defenders of Wildlife, *supra*, 504 U.S. at 560–61.

In Lewis v. Casey, 518 U.S. 343, 358 (1996), the Supreme Court reaffirmed this formulation:

> Since they are not mere pleading requirements, but rather an indispensable part of the plaintiffs case, each element of standing must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, i.e., with the manner and degree of evidence required at the successive stages of the litigation. At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we presume that general allegations embrace those specific facts that are necessary to support the claim. In response to a summary judgment motion, however, the plaintiff can no longer rest on such mere allegations, but must set forth by affidavit or other evidence specific facts, which for purposes of the summary judgment motion will be taken to be true. And at the final stage, those facts (if controverted) must be supported adequately by the evidence adduced at trial.

Lewis v. Casey, *supra*, 518 U.S. at 358.

3. The Receiver Has Standing

a. The Receiver Has Statutory Standing

As noted, the Defendants do not deny that the Receiver has statutory standing. Accordingly, they have waived any such claim.[299] In any event, the Receiver clearly has statutory standing as an ERISA fiduciary, under 29 U.S.C. § 1132(a), sub-sections (2) and (3), which state in pertinent part as follows:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought—

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[299] See *supra* at 79.

* * *

> (2) by the Secretary, or by a participant, beneficiary or **fiduciary** for appropriate relief under section 1109 of this title;
>
> (3) by a participant, beneficiary, or **fiduciary** (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

29 U.S.C. § 1132(a)(2) & (3) (emphasis supplied).

Insofar as the Plan is governed by ERISA, the Receiver is an ERISA fiduciary. S.E.C. v. Capital Consultants, LLC, No. CIV.00-1290-KI, 2002 WL 32502450, at *4 (D. Or. Dec. 5, 2002) ("It is undisputed that the Receiver is an ERISA fiduciary …because he has authority and control over ERISA plan assets…"); Solis v. J.P. Maguire Co. Salary Sav. Plan, No. 11-CV-2904 KAM JMA, 2012 WL 4060569, at *3 n.4 (E.D.N.Y. July 24, 2012) ("The receiver's duties fell within the statutory definition of a fiduciary because the receiver had the power to make decisions affecting plan policy for the duration of his or her appointment.").

Thus, court-appointed liquidators and bankruptcy trustees with control over ERISA plans are ERISA fiduciaries with standing to bring suit on behalf of the plan. See Mutual Life Ins. Co. of New York v. Yampol, 840 F.2d 421, 425 (7th Cir. 1988) (upholding standing of Illinois Director of Insurance acting as state[300] court appointed

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[300] When the Prospect Entities filed their motion to dismiss, they made no arguments concerning the state court's authority over the Plan. However, in their opposition to the proposed settlement between Plaintiffs and Defendants SJHSRI, RWH, and CCCB, the Prospect Entities took the position that the state court and, consequently, the Receiver had no jurisdiction over the Plan because of ERISA. See Dkt. # 75-1. Plaintiffs vigorously disputed that argument. Dkt. # 83. If the Prospect Entities held that view, it should have been asserted in their motion to dismiss as a complete defense. Anomalously, it has not been. Instead they are asking the Court to rule on it in connection with Plaintiffs' motion for settlement approval.

liquidator of ERISA plan to bring suit on behalf of the plan against other fiduciaries for breach of fiduciary duty) ("To strip the Director of fiduciary status would leave the individual most keenly aware of any breaches of duty by past fiduciaries without the ability to sue to obtain the benefit of ERISA's remedial provisions. While remedies of various description may be available in the states, a fundamental purpose behind ERISA was Congress's purpose to assure plan participants and fiduciaries sufficient and uniform remedies that traditional trust law had, in the view of Congress, all too often failed to provide."); McLemore v. Regions Bank, 682 F.3d 414, 420 (6th Cir. 2012) (bankruptcy trustee for investment advisor that was an ERISA fiduciary was authorized as successor fiduciary to sue co-fiduciaries who knowingly permitted investment advisor to steal ERISA plan assets) (trustee had standing due to "the unique role of a trustee acting as an ERISA fiduciary. The Trustee brings this suit in his role as an ERISA fiduciary, rather than his role as a trustee to the debtor's estate.").

As an ERISA fiduciary, the Receiver is entitled to sue for injuries to the Plan. See Beta Grp., Inc. v. Steiker, Greenaple, & Croscut, P.C., No. CV 15-213 WES, 2018 WL 461097, at *3 (D.R.I. Jan. 18, 2018) (Smith, C.J.) ("Moreover, Romeo, as a named fiduciary, is expressly permitted to assert claims for losses on behalf of the Plan stemming from fiduciary breaches.") (citing 29 U.S.C. § 1132(a)(2)). Thus, the Receiver has statutory standing to seek "appropriate relief" under 29 U.S.C. § 1109(a), which states in pertinent part as follows:

> (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other

> equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

The Receiver's claims include the allegation that Defendants SJHSRI and CCCB were Plan fiduciaries who breached their fiduciary duties to the Plan participants and the Plan, and that the remaining Defendants are liable under ERISA for aiding and abetting those breaches of fiduciary duty.[301]

b. The Receiver Has Constitutional Standing

i. The Defendants' Arguments

The Prospect Entities style their motion to dismiss as including a motion to dismiss under Rule 12(b)(1) for lack of standing. Prospect Memo. at 7 & 109. However, they make their argument in terms of ripeness, and then combine standing and ripeness with the argument that Plaintiffs' claims are not ripe until PBGC is joined in this proceeding, and until that happens, the Court cannot even determine whether Plaintiffs have a concrete injury for purposes of standing:

> Plaintiffs' ERISA-based claims against the Prospect Entities are not ripe primarily because Plaintiffs (in particular, the Receiver) have not yet taken the steps necessary to determine the Plan's (and the participants') true losses, if any. Those true losses can only be ascertained after the PBGC is added as a party to the lawsuit to terminate the Plan (or, acquiesce in its termination), undertake and discharge its statutory and fiduciary responsibilities, and pay any and all statutorily-guaranteed benefits. Only then would the Court be in a position to determine which, if any, of the Plan participants have sustained a Plan "loss" and, thus, have a concrete injury capable of conferring upon them the requisite standing.

Prospect Memo. at 11 (quoting Spokeo, Inc. v. Robins, *supra*, 136 S. Ct. at 1547).

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[301] FAC ¶¶ 362-372.

Although the Prospect Entities seek to have all of the Plaintiffs' claims dismissed for lack of standing and/or ripeness, Angell seeks dismissal only of the claims of the "Class Plaintiffs." Angell Memo. at 13 ("THE CLASS PLAINTIFFS LACK CONSTITUTIONAL STANDING TO BRING THIS LAWSUIT"). Angell argues that the Class Plaintiffs' alleged injuries are "speculative allegations of risk," and, therefore, they have not alleged the requisite injury in fact:

> 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.

Angell Memo. at 15 (quoting Lee v. Verizon Commc'ns, Inc., 837 F.3d 523, 546 (5th Cir. 2016) ("'[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.'").

ii. The Receiver Has Constitutional Standing

The Prospect Entities seek dismissal of the Receiver's claims on grounds of standing, but do not differentiate between the issue of whether the *Receiver* has an injury in fact and whether the *Plan participants* have an injury in fact. Nor do the Prospect Entities even bother to argue that the issues involved in determining the Receiver's constitutional standing are the same as the issues involved in determining the Plan participants' constitutional standing. Instead, by ignoring the issue they would have the Court mistakenly assume that there is no distinction between the Plaintiffs for purposes of constitutional standing, when in fact there are essential differences.

By alleging injuries to the Plan itself, the Receiver meets the requirement for constitutional standing, of injury in fact. In Nationwide Life Ins. Co. v. Haddock, 460 F. App'x 26, 28 (2d Cir. 2012) (summary order), the Second Circuit held that trustees of an employee benefit plan covered by ERISA had standing to sue plan fiduciaries (Nationwide) for disgorgement of hidden commissions, notwithstanding that plan participants may not have been injured thereby, stating as follows:

> As a preliminary matter, Nationwide argues that plaintiffs lack constitutional standing to seek disgorgement, citing decisions by this Court holding "that an ERISA Plan participant or beneficiary must plead a direct injury in order to assert claims [for monetary relief] on behalf of a Plan." *See, e.g., Central States Se. & Sw. Areas Health & Welfare Fund v. Merck–Medco Managed Care, L.L.C.,* 433 F.3d 181, 200 (2d Cir.2005). Nationwide misreads that line of authority. Plaintiffs are ERISA Plan trustees, *not* "Plan participant[s] or beneficiar[ies]." *Id.* Thus, their allegations of injuries to plans resulting from Nationwide's alleged breaches of fiduciary duties are in no sense indirect, and we have no difficulty concluding that plaintiffs have properly pleaded the required injury in fact.

See also Central States Southeast and Southwest Areas Health and Welfare Fund v. Merck-Medco Managed Care, L.L.C., 504 F.3d 229, 243 (2d Cir. 2007) (finding that trustee as fiduciary of employee benefit plan had constitutional standing to sue based on injuries to the plan).

Indeed, when filing a motion to dismiss for lack of constitutional standing, defendants typically only target plaintiffs who are plan participants, in acknowledgment that, for plaintiffs who are plan fiduciaries, the injury in fact requirement is satisfied by a showing of injury to the plan. See Carver v. Bank of New York Mellon, No. 15-CV-10180 (JPO), 2017 WL 1208598, at *3 (S.D.N.Y. Mar. 31, 2017) ("BNYM argues that all but one of the Plaintiffs lack constitutional standing in this case. BNYM distinguishes

between Plaintiffs . . . who are participants in either defined benefit plans or defined contribution plans—and Plaintiff Baumann—the 'Trustee Plaintiff,' who is a trustee of the Teamsters Local 945 Plan. BNYM does not challenge the Trustee Plaintiff's Article III standing at this stage of the proceedings, but does challenge the standing of the Participant Plaintiffs.") (citations to docket omitted).

4. The Named Plaintiffs and the Plaintiff Class Have Standing

a. They Have Statutory Standing

The Defendants do not dispute that all of the Plan participants have statutory standing to sue for violations of ERISA; nor could they, since ERISA expressly provides Plan participants with a civil cause of action, which satisfies the requirement for statutory standing in the clearest possible terms. See Bank of America Corp. v. City of Miami, Fla., *supra*, 137 S.Ct. at 1302 ("The question is whether the statute grants the plaintiff the cause of action that he asserts.").

Indeed, ERISA gives plan participants ready access to the federal courts:

> Litigation involving benefit plans is an integral part of ERISA law and practice. Indeed, the threshold provision of the Act contains Congress's expression of emphasis that it is the policy of ERISA to protect the interests of participants and beneficiaries by requiring enhanced reporting and disclosure of financial and other information, by establishing standards of conduct and responsibility for fiduciaries of benefit plans, and "**by providing for appropriate remedies, sanctions, and ready access to the Federal courts**." The resolution of disputes involving benefit plans is one measure of the success of Congress's effort to enhance the retirement income security of American workers.

2 ERISA Practice and Litigation § 11:1 (quoting 29 U.S.C. § 1001(b)) (emphasis supplied).

In addition to the express permission granted to "participants" under sub-sections (2) and (3) of 29 U.S.C. § 1132(a) quoted above, Plan participants are also empowered to bring a civil action by 29 U.S.C. § 1132(a) (1), which states in pertinent part as follows:

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan

ERISA defines "participant" as follows:

> (7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002 (7).

The Supreme Court addressed this definition in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989), stating:

> In our view, the term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," … or former employees who "have … a reasonable expectation of returning to covered employment" or who have "a colorable claim" to vested benefits. … In order to establish that he "may become eligible for benefits," a claimant must have a colorable claim that (1) he will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future.

Firestone Tire and Rubber Co. v. Bruch, supra, 489 U.S. at 117. All of the Named Plaintiffs and the putative class members clearly meet these requirements.

b. The Plan Participants have Constitutional Standing

i. Derivatively

The Defendants' claims that the Plan participants lack constitutional standing are based on the claim that the Plan participants lack individualized injury in fact. That argument implicitly presumes that the Named Plaintiffs, and the putative class of all of the Plan participants, cannot satisfy the Article III requirement of injury in fact derivatively based on injuries to the Plan, because the relief sought is to fund and otherwise benefit the Plan.[302]

Although neither the Supreme Court nor the First Circuit has directly addressed the question, the Second Circuit has approved derivative standing for plan participants.

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[302] The relief sought in the Complaint is to benefit the Plan. See FAC at 138 & 141 (seeking, *inter alia*, the following relief: "C. Ordering Defendants SJHSRI and CCCB **to fund the Plan** in accordance with ERISA's funding requirements; D. Requiring Defendants SJHSRI and CCCB **to make the Plan whole** for all contributions that should have been made pursuant to ERISA funding standards, and for interest and investment income on such contributions, and requiring said Defendants to disgorge any profits accumulated as a result of their fiduciary breaches; E. Ordering declaratory and injunctive relief as necessary and appropriate, including enjoining the Defendants from **further violating the duties, responsibilities, and obligations imposed on them by ERISA, with respect to the Plan**…") (emphasis supplied); FAC at 143-144 (seeking, *inter alia*, the following relief: "C. Ordering Defendants RWH, Prospect Chartercare, Angell, Corporation Sole, Diocesan Administration, Diocesan Service, Prospect Medical Holdings, Prospect East, Prospect SJHSRI, and Prospect RWH **to fund the Plan** in accordance with ERISA's funding requirements; D. Requiring Defendants RWH, Prospect Chartercare, Angell, Corporation Sole, Diocesan Administration, Diocesan Service, Prospect Medical Holdings, Prospect East, Prospect SJHSRI, and Prospect RWH **to make the Plan whole** for all contributions that should have been made pursuant to ERISA funding standards, and for interest and investment income on such contributions, and requiring Defendants to disgorge any profits accumulated as a result of their fiduciary breaches; E. Ordering declaratory and injunctive relief as necessary and appropriate, including enjoining Defendants RWH, Prospect Chartercare, Angell, Corporation Sole, Diocesan Administration, Diocesan Service, Prospect Medical Holdings, Prospect East, Prospect SJHSRI, and Prospect RWH **from further violating the duties, responsibilities, and obligations imposed on them by ERISA, with respect to the Plan**.") (emphasis supplied); and FAC ¶ 530 (" Defendants SJHSRI, RWH, and CCCB are liable to Plaintiffs on one or more of the claims asserted herein, for which Defendants CC Foundation, Prospect Chartercare, Prospect East, Prospect Medical Holdings, Prospect SJHSRI, and Prospect RWH are liable to Plaintiff as successors of Defendants SJHSRI, RWH, and CCCB.").

See, e.g., Fletcher v. Convergex Grp., L.L.C., 679 F. App'x 19, 19–21 (2d Cir. 2017) ("We conclude that allegations describing Convergex's breach of fiduciary duties of prudence and loyalty under ERISA, its violation of ERISA's prohibited transactions provision, and the resulting financial loss sustained by the Central States Plan **are sufficient to confer Article III standing on Fletcher in his representative capacity as a Plan participant**.") (emphasis supplied) (citing L.I. Head Start Child Development Services, Inc. v. Economic Opportunity Com'n of Nassau County, Inc., 710 F.3d 57, 67 n.5 (2d Cir. 2013)).

The cited case of L.I. Head Start involved breach of fiduciary duty claims by participants in defined benefit pension plans against plan trustees for underfunding the plan, in which the plan trustees defended on the grounds that the plan participants lacked constitutional standing in that they had not demonstrated that they suffered an injury in fact. In rejecting that argument, the Second Circuit stated as follows:

> We also reject the Administrators' argument that LIHS and the Class lack constitutional standing because they have not suffered an injury in fact. **As discussed, LIHS and the Class have asserted their claims in a derivative capacity, to recover for injuries to the Plan caused by the Administrators' breach of their fiduciary duties. This is injury in fact sufficient for constitutional standing.**

L.I. Head Start Child Development Services, Inc., *supra*, 710 F.3d at 67 n.5 (emphasis supplied).

The court in Carver v. Bank of New York Mellon, No. 15-CV-10180 (JPO), 2017 WL 1208598 (S.D.N.Y. Mar. 31, 2017) rejected similar arguments, also in the context of defined benefit plans, stating as follows:

> BNYM argues that the Participant Plaintiffs who are participants in defined benefit plans lack Article III standing because they fail to allege an

> individualized injury in the form of a reduction in their defined benefits, as opposed to an injury to the plan generally, that is traceable to the alleged ERISA violation and redressable by the relief sought. BNYM contends that the Participant Plaintiffs who are participants in defined contribution plans lack Article III standing because the complained-of injury is merely a "de minimis individualized injury." **Yet the Second Circuit has recently affirmed that similarly situated plaintiffs have constitutional standing when suing on behalf of an ERISA plan in a derivative or representative capacity, as opposed to in their individual capacity**.

Carver v. Bank of New York Mellon., *supra*, 2017 WL 1208598, at *3 (emphasis supplied). The court in Carver stated that derivative standing relieves plan participants of the obligation to demonstrate individual injury in fact:

> Where, as here, Plaintiffs are suing in their representative or derivative capacities on behalf of the Plans, Plaintiffs need not demonstrate individualized injury when they have alleged injury to the Plans caused by Defendants

Id. at *4. In our case, the Plan participants are proceeding both derivatively on behalf of the Plan, and in their individual capacity.

On the other hand, certain other courts of appeal[303] have reached the opposite conclusion, sometimes over strong dissents. See, e.g., Perelman v. Perelman, 793 F.3d 368, 376 (3d Cir. 2015) (stating that "other federal appellate courts have unanimously rejected" representative or derivative standing in such circumstances, but failing to note Second Circuit's contrary position); Lee v. Verizon Commc'ns, Inc., 837 F.3d 523, 547-48 (5th Cir. 2016). But see McCullough v. AEGON USA Inc., 585 F.3d 1082, 1088 (8th Cir. 2009) (dissent) ("[T]he Supreme Court's recent decision in *Sprint*

[303] From Plaintiffs' research it does not appear that the First Circuit or any District Courts in the First Circuit have addressed this issue.

Communications Co. v. APCC Services, Inc., 554 U.S. 269, 128 S. Ct. 2531, 171 L.Ed.2d 424 (2008), compels us to reach a different result…").

However, the Court need not even reach the issue of whether Plan participants may meet the injury in fact requirement derivatively, based solely upon injuries to the Plan, because the Plan participants can demonstrate individualized harm.

ii. Because Defendants Enhanced the Risk of Plan Insolvency and SJHSRI Is Unable to Make Up the Deficit

As noted, Angel and the Prospect Entities Defendants claim that the Plan participants lack standing because they are based upon "speculative allegations of risk."

However, Defendants inexcusably ignore the standard set by the Supreme Court for proving "individualized harm" in the context of defined benefit plans:

> Misconduct by the administrators of a defined benefit plan will not affect an individual's entitlement to a defined benefit **unless it creates or enhances the risk of default by the entire plan.**

LaRue v. DeWolff, Boberg & Associates, Inc., 552 U.S. 248, 255 (2008) (emphasis supplied).

The lower federal courts have embraced the Supreme Court's statement in LaRue v. DeWolff, Boberg & Assocs. as the standard for determining whether participants in defined benefit pension plans have individualized harm sufficient to confer constitutional standing for violations of ERISA, such as in the following cases, all of which quote this statement from LaRue v. DeWolff, Boberg & Assocs.:

> Rollins v. Dignity Health, 338 F. Supp. 3d 1025, 1040 (N.D. Cal. 2018) ("'[A] trustee's misconduct will give rise to Article III standing where the [m]isconduct ... creates or enhances the risk of default by the entire

plan.'") (quoting Slack v. Int'l Union of Operating Eng'rs, No. C-13-5001 EMC, 2014 WL 4090383, at *14 (N.D. Cal. Aug. 19, 2014));

Adedipe v. U.S. Bank, Nat. Ass'n, 62 F. Supp. 3d 879, 891 (D. Minn. 2014) ("In a standing analysis, the import of this alleged increased risk of default can only lie in the concomitant increase in the risk that the participants will not receive the level of benefits they have been promised due to the Plan being inadequately funded at termination.");

Fox v. McCormick, 20 F. Supp. 3d 133, 141 (D.D.C. 2013) ("[A] a participant in a defined benefit plan can sue trustees for their failure to collect contributions when the participant faces a risk of non-payment of his pension—such as when trustees' dereliction threatens the financial stability of a plan—or when the participant specifically retains a reversionary interest in excess contributions if monies remain after all benefits are paid.");

Perelman v. Perelman, 919 F. Supp. 2d 512, 518 (E.D. Pa. 2013) ("However, the [third amended complaint]'s claims for monetary relief under § 502(a)(2) require that Jeffrey allege an injury in fact. As a beneficiary to a defined benefit pension plan, he cannot establish standing to sue on behalf of the Plan absent a plausible allegation that the breach of fiduciary duty created or enhanced a risk of default by the entire plan."), aff'd, supra, 793 F.3d at 374 ("By contrast, there is some support for the notion that a participant or beneficiary in a defined benefit plan has suffered an injury sufficient to pursue a claim for 'make-whole' equitable monetary relief under § 502(a) where the fiduciary's alleged misconduct 'creates or enhances the risk of default by the entire plan.'") (quoting LaRue v. DeWolff, Boberg & Assocs., Inc.);

Lee v. Verizon Commc'ns, Inc., 954 F. Supp. 2d 486, 497 (N.D. Tex. 2013) ("For defined benefit plans such as the Plan, a decrease in the value of plan assets does not necessarily result in an injury in fact because the benefit amount is fixed regardless of the value of assets in the Plan. '[T]he employer typically bears the entire investment risk and—short of the consequences of plan termination—must cover any underfunding as the result of a shortfall that may occur from the plan's investments.' *Hughes Aircraft*, 525 U.S. at 439, 119 S.Ct. 755. Therefore, a decrease in the amount of plan assets 'will not affect an individual's entitlement to a defined benefit unless it creates or enhances the risk of

> default by the entire plan.' *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 255, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008).").

In short, standing for a participant in a defined benefit pension plan governed by ERISA depends upon whether the alleged violations of ERISA resulted in the plan being underfunded. See Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 902 n.8 ("The Court recognizes, as has the Eighth Circuit, that one implication of the standing analysis outlined in *Harley* is that a private cause of action to remedy a fiduciary breach will be available to a participant when a plan is underfunded, but the same participant will have no recourse for the very same misconduct when the plan is overfunded.") (finding plan participant standing because alleged ERISA violations resulted in substantial underfunding) (citing Harley v. Zoesch, 413 F.3d 866, 871, 908 n.5 (8th Cir. 2005)).

Defendants fail to cite and we have not found a single case involving a defined benefit plan in which plan participants alleged that the defendants were responsible for the plan being significantly underfunded, where it was found that the plan participants lacked an individualized injury in fact sufficient to confer constitutional standing.

There is a debate in the law over whether enhanced risk of default of a defined benefit plan is sufficient to show individualized harm, regardless of the plan sponsor's solvency. Although that precise question is irrelevant here, since Plaintiffs also allege (and it should be undisputed) that SJHSRI has insufficient funds to make up the deficit, those cases warrant acknowledgement, because the existence and terms of that debate establishes *a fortiori* that the combination we have here, of increased risk of default *and* plan sponsor inability to make up the deficit, is sufficient to meet the Article III requirements of individualized harm.

In Adedipe v. U.S. Bank, Nat. Ass'n, plan participants alleged that "'[a]s a result of the several violations of ERISA committed by Defendants, the Plan lost $1.1 billion in 2008 and has plummeted from being significantly overfunded at the end of 2007 to being significantly underfunded,'" but the plan sponsor (U.S. Bancorp) asserted it was "fully capable of meeting the minimum funding obligations set by the statute—as evidenced by the $11.44 billion in cash it generated from its ongoing operations in 2013 and the $61.7 billion in liquidity it had on hand 'to cover unanticipated expenses."' Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 891.

Against this factual background, the court stated that "[t]he question, then, is whether, against the undisputed evidence of U.S. Bancorp's financial strength, the Plaintiffs' lone assertion that the Defendants' fiduciary breaches caused the Plan to go 'from being significantly overfunded ... to being significantly underfunded' is a sufficient showing of a personal injury in fact at this stage of the litigation." Id. The court answered the question in the affirmative, and in the process dismissed the significance of PBGC coverage. Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 893 ("Despite the appeal of the Defendants' position, none of these discussions suggest that the analysis of participants' injuries in this context is to turn on the financial health of the plan sponsor or the availability of PBGC insurance to cover a potential shortfall at plan termination."). However, the Adedipe court added the qualification that the plaintiffs must demonstrate underfunding using a relevant method of estimating the deficit. Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 892 ("Consistent with *Harley* [*v. Zoesch*, 413 F.3d 866 (8th Cir. 2005)], then, the Plaintiffs bear the burden of

alleging the absence of a surplus sufficient to absorb the loss of Plan assets caused by the Defendants' fiduciary breaches under a relevant valuation method.").

Thus, under Adedipe, plan participants must allege that the plan is underfunded based upon "a relevant valuation method." In Adedipe, the court rejected as irrelevant, in the absence of any intention to terminate the plan, a valuation that calculated the deficit on the assumption that the plan needed sufficient assets to fund *termination*[304] of the plan. Id. However, as the court noted, the plaintiffs in that case were not offering a termination valuation. Instead, their experts valued the plan on an ongoing basis, for which it was 80% funded.

The defendant U.S. Bancorp agreed with the calculation but asked the court to rule that 80% did not constitute underfunding, because ERISA "makes no distinction between plans that are between 80% and 100% funded or higher" on an ongoing basis. The court described that fact as "somewhat beside the point." Instead, the court held that the appropriate measure by which to determine whether the plan was significantly underfunded so as to constitute a significantly increased risk of default sufficient to constitute an injury in fact for purposes of Article III standing was whether the plan failed to comply with "ERISA's minimum funding standards." Id. As the court stated:

> Under these pension funding provisions, with respect to any defined benefit plan "in which the value of plan assets" is less than "the present value of all benefits accrued or earned under the plan as of the beginning of the year," ERISA obligates the employer to make the "minimum required contributions" necessary to amortize that shortfall over the ensuing seven years. 29 U.S.C. §§ 1082–83.

[304] As discussed above, satisfaction of termination liability requires significantly more funds than if the plan deficit is determined on an ongoing basis with the assumption that plan assets will earn investment rates of return. By contrast, plan termination requires the immediate purchase of annuities that are priced on a more conservative (i.e. lower) estimated rate of return.

Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 894-95 (citing 29 U.S.C. §§ 1082–83). It apparently was undisputed that the plan deficit violated ERISA's minimum funding standards, and the court concluded:

> At least by these relevant measures, then, the Plaintiffs have adequately alleged that the Plan lacked a surplus large enough to absorb the losses at issue. Accordingly, the Plaintiffs have satisfied their burden of alleging that they have suffered a personal injury in fact . . . .

Adedipe v. U.S. Bank, Nat. Ass'n, *supra*, 62 F. Supp. 3d at 895.

Thus, under Adedipe, plan participants that demonstrate a significant underfunding using a "relevant valuation method" satisfy their burden of alleging individualized injury in fact, even if the plan sponsor is fully capable of making up the deficit. Here the Plan participants clearly meet this test, of showing "the absence of a surplus sufficient to absorb the loss of Plan assets caused by the Defendants' fiduciary breaches under a relevant valuation method," based upon SJHSRI's allegations in the Receivership Petition, and employing Defendant Angell's calculations attached thereto, which demonstrate insufficient assets under either a scenario of plan termination or plan continuation.

On the other hand, in at least one case, courts have found individualized harm lacking notwithstanding that the defined benefit plan was substantially underfunded, because the plan sponsor (Verizon) was able to make up the deficit. See Lee v. Verizon Commc'ns, Inc., *supra*, 954 F. Supp. 2d 486, in which the court stated:

> The Non–Transferee Class alleges that Verizon caused losses to the Plan by violating the restriction on accelerated benefit distributions when a plan is less than 80% funded, which purportedly caused the Plan to fund the entire $8.4 billion payment to Prudential, and by using Plan assets to pay the $1 billion in expenses for the annuity transaction, in violation of the exclusive benefit rule. The Non–Transferee Class also asserts that

> Verizon left the Plan in a less stable financial condition, in violation of its fiduciary duties concerning investing Plan assets. It avers that this conduct harms the Plan, leaves it underfunded and insufficient to support all of the expected payments to the Non–Transferee Class, and thus jeopardizes the financial security of the pension benefits of the class members.
>
> The parties dispute whether the Plan was in fact underfunded and whether Verizon violated the Internal Revenue Code or the exclusive benefit rule in entering into the annuity transaction. The court need not address these arguments or the supporting evidence. This is because, assuming *arguendo* that these alleged violations breached Verizon's fiduciary duties and caused loss to the Plan, the Non–Transferee Class has failed to allege that its members have not received the plan benefits to which they are entitled, **or, for example, that Verizon as plan sponsor cannot make the necessary contributions to the Plan so that reductions are avoided.** Because the Non–Transferee Class has failed to allege such facts, the amended complaint is insufficient to establish the injury in fact necessary for Article III standing.

Lee v. Verizon Commc'ns, Inc., *supra*, 954 F. Supp. 2d at 498 (emphasis supplied).

On appeal, the Court of Appeals affirmed based on essentially the same conclusions, stating as follows:

> Pundt's allegation that the plan was underfunded, and less financially stable, merely increases the relative likelihood that Verizon will have to cover a shortfall. However, Pundt's allegations do not further allege the realization of risks which would create a likelihood of direct injury to participants' benefits. To wit, Pundt 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; on the contrary, Appellants concede on appeal that the actuarial underfunding resulted in no direct injury to Pundt.

Lee v. Verizon Commc'ns, Inc., 623 F. App'x 132, 149 (5th Cir. 2015) (emphasis supplied).[305]

[305] The full citation is: Lee v. Verizon Commc'ns, Inc., 623 F. App'x 132, 149 (5th Cir. 2015), *cert. granted, judgment vacated sub nom.* Pundt v. Verizon Commc'ns, Inc., 136 S. Ct. 2448, 195 L. Ed. 2d 260 (2016).

The Adedipe court has the better argument. It is difficult to understand why plan participants have no injury from their employer's breach of fiduciary duty to fund the plan, simply because their employer presently has the means and an independent obligation to fully fund the plan. Generally speaking, the fact that a solvent defendant has liability both in tort and contract would not deny standing to an injured party who sues on only one of those theories. Similarly, the possibility that a party in breach of contract may have sufficient funds to cure the breach does not mean there is no injury prior to the cure.

But that issue is not before the Court, because SJHSRI does not have the funds to make up the deficit. In other words, the Plan participants have demonstrated an individualized injury in fact sufficient to meet the requirements of constitutional standing, under either of the standards set by the courts in Adedipe or Lee v. Verizon Commc'ns, Inc.

iii. Notwithstanding the Possibility of PBGC Coverage

(A) Summary of Defendants' Arguments

As discussed below, Defendants are seeking to dismiss Plaintiffs' ERISA claims for "failure to join an indispensable party." That motion is addressed later in this memorandum. However, at least the Prospect Entities also rely on the role of PBGC to

On remand, the Fifth Circuit affirmed its prior decision. Lee v. Verizon Commc'ns, Inc., 837 F.3d 523 (5th Cir. 2016).

support their claim that Plaintiffs lack constitutional standing. According to the Prospect Entities:

> Plaintiffs' ERISA-based claims against the Prospect Entities are not ripe primarily because Plaintiffs (in particular, the Receiver) have not yet taken the steps necessary to determine the Plan's (and the participants') true losses, if any. Those true losses can only be ascertained after the PBGC is added as a party to the lawsuit to terminate the Plan (or, acquiesce in its termination), undertake and discharge its statutory and fiduciary responsibilities, and pay any and all statutorily-guaranteed benefits. Only then would the Court be in a position to determine which, if any, of the Plan participants have sustained a Plan "loss" and, thus, have a concrete injury capable of conferring upon them the requisite standing.

Prospect Memo. at 11 (quoting Spokeo, Inc. v. Robins, supra, 136 S. Ct. at 1547). Accordingly, Defendants' arguments concerning PBGC also must be considered in connection with their motions to dismiss under Rule 12(b)(1) for lack of standing.

(B) PBGC Is Irrelevant under the Standard Set in LaRue v. DeWolff, Boberg & Associates, Inc.

Under the standard stated in LaRue v. DeWolff, Boberg & Associates, Inc., as applied by the lower federal courts, participants in a defined benefit plan satisfy the requirement for injury in fact when the complained-of ERISA violation "creates or enhances the risk of default by the entire plan." LaRue, 552 U.S. at 255. The Supreme Court did not create a separate test or make an exception for defined benefit plans which are covered by a PBGC guarantee. Such an exception would have swallowed the rule, since LaRue was an ERISA case, and virtually all defined benefit plans covered by ERISA are also covered by a PBGC guarantee. Accordingly, the role of PBGC is irrelevant to Plaintiffs' standing.

(C) PBGC Is Especially Irrelevant to the Receiver's Claims

As previously noted, the Receiver's standing, including injury in fact, is satisfied by allegations of injury to the Plan. The Plan is a juridical entity, not merely a means of providing benefits to plan participants. Pickett v. Cigna Healthplan of Texas, Inc., 742 F. Supp. 946, 946 (S.D. Tex. 1990) ("It [the plan] is a juridical entity separate and distinct from the providers of the plan's services and from the plan's trustees.") (citing 29 U.S.C. § 1132(g)(1) ("An employee benefit plan may sue or be sued under this subchapter as an entity.")). See also Pressroom Unions-Printers League Income Sec. Fund v. Continental Assur. Co., 700 F.2d 889, 893 (2d Cir. 1983) ("Subsection (d)(1) [of 29 U.S.C. § 1132] only establishes the right of employee benefit plans created by ERISA to sue and be sued like corporations and other legal entities. Without such a provision a pension plan would not be a legally cognizable body."). As such, it can be injured, and the Receiver as an ERISA fiduciary can bring suit to recover damages and other relief for such injuries.

Injuries to the Plan not only do not necessarily result in PBGC involvement; they usually do not involve PBGC. As discussed below, the only circumstance in which PBGC becomes involved with a plan is through *termination of the plan*. Plan termination certainly does not make the plan whole. Upon an involuntary termination by PBGC, PBGC takes over the remaining assets of the plan. That also is a clear detriment to the plan.

(D) What PBGC Is, How It Operates, How It Is Funded, and the Risks That PBGC Itself Is Facing

The Prospect Entities try to persuade the Court that PBGC is a panacea, stating that the Receiver is trying "to do the job that an entire federal agency has been created to fulfill—which it does at taxpayer expense and without depleting the assets of a retirement plan that the Receiver himself claims is terribly underfunded." Prospect Memo. at 1. Angell expressly joins in that argument. Angell Memo. at 13 n.2 ("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.").

However, that argument is dead wrong as to how PBGC is funded, and otherwise neglects to address what PBGC is, how it operates, and the risks PBGC itself is facing, all of which make the role of PBGC too speculative to be relevant to the determination of whether the Plan participants have individualized injuries in fact sufficient to confer constitutional standing.

"PBGC is a self-financed federal corporation. **The federal government is not responsible for the agency's liabilities or obligations**." Lee T. Polk, ERISA Practice and Litigation § 10:36 (emphasis supplied). See In re UAL Corp., 428 F.3d 677, 680 (7th Cir. 2005) ("Currently, PBGC self-finances this mission through four sources of income: insurance premiums paid by current sponsors of active plans, assets from terminated plans taken over by PBGC, recoveries from former sponsors of terminated plans, and PBGC's own investments.").

PBGC acts as an insurer, both in funding and function. PBGC's current Mission Statement states in pertinent part as follows:

> The Pension Benefit Guaranty Corporation (PBGC) protects the retirement incomes of more than 40 million American workers in nearly 24,000 private-sector defined benefit pension plans. A defined benefit plan provides a specified monthly benefit at retirement, often based on a combination of salary and years of service. PBGC was created by the Employee Retirement Income Security Act of 1974 to encourage the continuation and maintenance of private-sector defined benefit pension plans, provide timely and uninterrupted payment of pension benefits, and keep pension insurance premiums at a minimum.
>
> **PBGC is not funded by general tax revenues. PBGC collects insurance premiums from employers that sponsor insured pension plans, earns money from investments and receives funds from pension plans it takes over**.

https://www.pbgc.gov/about/who-we-are (emphasis added).

PBGC itself is at risk. See PBGC 2017 Annual Report at 10 & 27 (https://www.pbgc.gov/sites/default/files/pbgc-annual-report-2017.pdf) (reporting a combined deficit of $75.966 billion, comprised of a $10.9 billion deficit for the single employer program, and a $65.1 billion deficit for the multi-employer program). The United States Government Accountability Office ("GAO")[306] since 1990 has been reporting on government operations and programs that the GAO considers "high-risk." https://www.gao.gov/highrisk/overview/background. Every two years the GAO publishes a report to Congress that "identifies government operations with greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges." GAO 3-17-317 Highlights. The GAO "designated the [PBGC] single-employer program as high risk in

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[306] See https://www.gao.gov/about("The U.S. Government Accountability Office (GAO) is an independent, nonpartisan agency that works for Congress. Often called the 'congressional watchdog,' GAO examines how taxpayer dollars are spent and provides Congress and federal agencies with objective, reliable information to help the government save money and work more efficiently.") (accessed January 18, 2019).

July 2003 and added the multiemployer program in January 2009." GAO 3-17-317 at 609.

The latest GOA "High Risk" report, issued in February of 2017, analyzed why PBGC's risk is high, and stated the GAO's conclusions as to "what is to be done," as follows:

> Although Congress and PBGC have taken significant and positive steps to strengthen the agency over the past 3 years, concerns persist related to the multiemployer program and challenges related to PBGC's overall funding structure and governance. While changes were made with passage of MPRA [the Multiemployer Pension Reform Act of 2014], PBGC officials believe there is a 50 percent chance that the multiemployer program will be insolvent by the year 2025, and after that, the risk of insolvency rises rapidly—reaching 90 percent by 2032. Further, the premium structure for PBGC's single-employer program continues to result in rates that do not align with the risk the agency insures against and the effectiveness of PBGC's board remains hampered by its size and composition.
>
> Moreover, PBGC continues to face the ongoing threat of losses from the termination of underfunded plans, while grappling with a steady decline in the defined benefit pension system. With each passing year, fewer employers are sponsoring defined benefit plans and the sources of funds to finance future claims are becoming increasingly inadequate. **Absent additional steps to improve PBGC's finances, the long-term financial stability of the agency remain uncertain and the retirement benefits of millions of American workers and retirees could be at risk of dramatic reductions.**

GAO 3-17-317 at 615 (emphasis supplied).

For these "additional steps" to occur, however, *congressional action* would be required. The GAO 2017 report made the following suggestions to Congress:

> To improve the long-term financial stability of both PBGC's insurance programs, Congress should consider:

> • authorizing a redesign of PBGC's single employer program premium structure to better align rates with sponsor risk;
>
> • adopting additional changes to PBGC's governance structure—in particular, expanding the composition of its board of directors;
>
> • strengthening funding requirements for plan sponsors as appropriate given national economic conditions;
>
> • working with PBGC to develop a strategy for funding PBGC claims over the long term, as the defined benefit pension system continues to decline; and
>
> • enacting additional structural reforms to reinforce and stabilize the multiemployer system that balance the needs and potential sacrifices of contributing employers, participants and the federal government.

GAO 3-17-317 at 615-16. Predicating the Plan participants' welfare on effective future congressional action to stabilize PBGC would be both speculative and risky, to say the least.

(E) PBGC Guarantee is Predicated on Plan Termination

PBGC's coverage obligation is set forth in 29 U.S.C. § 1322 as follows:

> Subject to the limitations contained in subsection (b), the corporation shall guarantee, in accordance with this section, the payment of all nonforfeitable benefits (other than benefits becoming nonforfeitable solely on account of the termination of a plan) under a single-employer plan **which terminates at a time when this subchapter applies to it**.

29 U.S.C. § 1322 (emphasis supplied). Thus, the issues of both 1) whether a pension plan's benefits are guaranteed by PBGC, and 2) the amount of that guarantee, are to be determined *at the time the plan is terminated*.

Accordingly, PBGC's guarantee is "plan termination insurance." 29 U.S.C. § 1001(c) ("It is hereby further declared to be the policy of this chapter to protect

interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring **plan termination insurance**.") (emphasis supplied). See United Food and Commercial Workers Union-Employer Pension Fund v. Rubber Associates, Inc., 812 F.3d 521, 525 (6th Cir. 2016) ("With the enactment of ERISA in 1974, Congress created the Pension Benefit Guaranty Corporation ("PBGC") to administer a **plan termination insurance program**.") (citations omitted and emphasis supplied).

However, the Plan has not been terminated, such that the benefits of Plan participants are not currently guaranteed by PBGC, even if it were assumed that the Plan is covered by ERISA. Accordingly, PBGC has no possible present obligation to determine coverage, much less provide insurance to the Plan participants.

(F) PBGC Cannot Be Compelled to Terminate the Plan or Assert a Claim

PBGC's authority to terminate a pension plan is set forth in 29 U.S.C. § 1342(a), which states in pertinent part as follows:

> (a) Authority to institute proceedings to terminate a plan
>
> The corporation **may** institute proceedings under this section to terminate a plan whenever it determines that—
>
>> (1) the plan has not met the minimum funding standard required under section 412 of Title 26, or has been notified by the Secretary of the Treasury that a notice of deficiency under section 6212 of Title 26 has been mailed with respect to the tax imposed under section 4971(a) of Title 26,
>>
>> (2) the plan will be unable to pay benefits when due,

> > (3) the reportable event described in section 1343(c)(7) of this title has occurred, or
> >
> > (4) the possible long-run loss of the corporation with respect to the plan may reasonably be expected to increase unreasonably if the plan is not terminated.
>
> The corporation **shall** as soon as practicable institute proceedings under this section to terminate a single-employer plan whenever the corporation determines that the plan does not have assets available to pay benefits which are currently due under the terms of the plan.

29 U.S.C. § 1342(a) (emphasis supplied).

The term "may" connotes discretion, especially when used in contraposition to the word "shall." Jama v. Immigration and Customs Enforcement, 543 U.S. 335, 346 (2005) (construing 8 U.S.C. § 1231) ("The word 'may' customarily connotes discretion. That connotation is particularly apt where, as here, 'may' is used in contraposition to the word 'shall'…") (citation omitted). See also Kelly v. United States, 924 F.2d 355, 360 (1st Cir. 1991) (holding that the discretionary function exception applies when statutory language "interweave[s] imperatives with weaker, precatory verbs and generalities more characteristic of discretion than of mandatory directives"); SESCO Enterprises, LLC ex rel. Schubiger v. United States, No. CIV 10-1470 AET, 2010 WL 4749327, at *3 (D.N.J. Nov. 16, 2010) ("Under established doctrine, mandatory statutory language (e.g. 'shall') supports judicial review while precatory language (e.g. 'may') bespeaks discretion."), vacated and remanded on other grounds, 450 F. App'x 141 (3d Cir. 2011).

Thus, PBGC has discretion when and if it will terminate a plan under 29 U.S.C. § 1342(a) sub-sections (1) – (4), unless PBGC determines "that the plan does not have assets available to pay benefits which are currently due under the terms of the plan," in which case PBGC is required to terminate the plan as soon as practicable.

This construction of the statute is further supported by the language of 29 U.S.C. § 1342(c)(1), which concerns PBGC's commencement of proceedings in the United States District Court to terminate a plan pursuant to its enforcement authority under 29 U.S.C. § 1342(a). 29 U.S.C. § 1342(c)(1) refers to that enforcement authority as sometimes mandatory and at other times discretionary, as follows:

> (1) **If the corporation is required under subsection (a) of this section to commence proceedings under this section with respect to a plan or, after issuing a notice under this section to a plan administrator, has determined that the plan should be terminated, it may**, upon notice to the plan administrator, apply to the appropriate United States district court for a decree adjudicating that the plan must be terminated in order to protect the interests of the participants or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the fund

29 U.S.C. § 1342(c)(1) (emphasis supplied). The contrast between the statutory language of "the corporation is required," on the one hand, and PBGC "has determined that the plan should be terminated," on the other hand, illustrates the mandatory/discretionary dichotomy. The two scenarios of 1) PBGC is "required" to commence proceedings to terminate a plan, or 2) PBGC "has determined that the plan should be terminated" confirm that PBGC has discretion when and if it will terminate a plan under sub-sections (1) – (4), unless PBGC determines "that the plan does not have assets available to pay benefits which are currently due under the terms of the plan."

If an agency decision to take enforcement action is discretionary, the agency's decision *not to take such action* is not reviewable by the courts. This issue was discussed extensively by the Supreme Court in Heckler v. Chaney, 470 U.S. 821 (1985), as follows:

> This Court has recognized on several occasions over many years that an agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion. This recognition of the existence of discretion is attributable in no small part to the general unsuitability for judicial review of agency decisions to refuse enforcement.
>
> The reasons for this general unsuitability are many. First, an agency decision not to enforce often involves a complicated balancing of a number of factors which are peculiarly within its expertise. Thus, the agency must not only assess whether a violation has occurred, but whether agency resources are best spent on this violation or another, whether the agency is likely to succeed if it acts, whether the particular enforcement action requested best fits the agency's overall policies, and, indeed, whether the agency has enough resources to undertake the action at all. An agency generally cannot act against each technical violation of the statute it is charged with enforcing. The agency is far better equipped than the courts to deal with the many variables involved in the proper ordering of its priorities. Similar concerns animate the principles of administrative law that courts generally will defer to an agency's construction of the statute it is charged with implementing, and to the procedures it adopts for implementing that statute.
>
> In addition to these administrative concerns, we note that when an agency refuses to act it generally does not exercise its coercive power over an individual's liberty or property rights, and thus does not infringe upon areas that courts often are called upon to protect. Similarly, when an agency does act to enforce, that action itself provides a focus for judicial review, inasmuch as the agency must have exercised its power in some manner. The action at least can be reviewed to determine whether the agency exceeded its statutory powers. Finally, we recognize that an agency's refusal to institute proceedings shares to some extent the characteristics of the decision of a prosecutor in the Executive Branch not to indict-a decision which has long been regarded as the special province of the Executive Branch, inasmuch as it is the Executive who is charged by the Constitution to "take Care that the Laws be faithfully executed." U.S. Const., Art. II, § 3.

Heckler v. Chaney, *supra*, 470 U.S. at 831-32 (citations omitted). Thus, the general rule is that agency non-enforcement decisions are not judicially reviewable. Baltimore Gas

and Elec. Co. v. F.E.R.C., 252 F.3d 456, 459 (D.C. Cir. 2001) ("*Chaney* sets forth the general rule that an agency's decision not to exercise its enforcement authority, or to exercise it in a particular way, is committed to its absolute discretion. Such matters are not subject to judicial review.").

The principle that agency *non-enforcement* is not judicially reviewable applies to PBGC. Thus, it has been held that the decision of PBGC, after it takes over a plan, *not to* assert the Plan's claims against third parties is not judicially reviewable. Paulsen v. CNF Inc., 559 F.3d 1061, 1085 (9th Cir. 2009) ("Based on the presumption in *Heckler v. Chaney*, 470 U.S. 821, 105 S. Ct. 1649, 84 L.Ed.2d 714 (1985), we hold that PBGC's discretionary decision not to pursue such claims is not subject to judicial review."). In Paulsen the Ninth Circuit addressed the applicability to PBGC of the Heckler v. Chaney presumption in depth, stating in part as follows:

> Also favoring application of the jurisdictional bar is the breadth of 29 U.S.C. § 1342(d)(1)(B)(iv)—from which PBGC derives the power to sue—and the lack of standards by which a court may review PBGC's decision not to sue on behalf of the plan. There is no "meaningful standard" against which to judge PBGC's decision not to act. See, e.g., *Port of Seattle*, 499 F.3d at 1027.
>
> PBGC must weigh additional considerations that are within the ambit of its peculiar expertise. PBGC has a broad set of agency purposes, not all of which conclusively favor suing each time it has an arguable claim. Its purposes are "(1) to encourage the continuation and maintenance of voluntary private pension plans for the benefit of their participants, (2) to provide for the timely and uninterrupted payment of pension benefits to participants and beneficiaries under plans ..., and (3) to maintain premiums established by [PBGC] ... at the lowest level consistent with [statutory obligations]." 29 U.S.C. §§ 1302(a)(1)-(3) (alterations added). Further, PBGC derives its funding from Congressionally-authorized and plan sponsor-paid insurance premiums, investment income, pooled assets from terminated plans for which it acts as trustee, and recoveries from former sponsors of terminated plans. See 29 U.S.C. §§ 1305, 1342(a).

> Taken together, PBGC must balance its statutory duties to all stakeholders, including premium payers, participants and beneficiaries in ongoing plans, and those in all of its terminated plans.

Paulsen v. CNF Inc., *supra*, 559 F.3d at 1086-87.

This principle has been applied to preclude judicial review of PBGC non-enforcement decisions concerning the *termination* of a defined benefit pension plan, specifically PBGC's decision not to issue a notice of compliance, which is a prerequisite for a voluntary termination to go forward. See Becker v. Weinberg Group, Inc. Pension Trust, 473 F. Supp. 2d 48 (D.D.C. 2007). That is especially relevant insofar as the Prospect Entities suggest that PBGC can be compelled to terminate the Plan. In Becker, the court rejected the plan participants' claims that PBGC's decision not to issue a notice of compliance was unjustifiable, and then provided the following, alternative basis for its refusal to enjoin PBGC:

> Second, even if the Court had found in Plaintiff's favor, the Court lacks jurisdiction to review her claim against PBGC because its decision to exercise its enforcement authority in this area is committed by law to the agency's discretion by law. 5 U.S.C. § 701(a)(2); see *Heckler v. Chaney*, 470 U.S. 821, 105 S.Ct. 1649, 84 L.Ed.2d 714 (1985). Under *Chaney*, an agency's decision not to exercise its enforcement authority, or to exercise it in a particular way, is committed to its absolute discretion and is not subject to judicial review. *Balt. Gas & Elec. Co. v. FERC*, 252 F.3d 456, 459 (D.C.Cir.2001) (citing *Chaney*, 470 U.S. at 831, 105 S.Ct. 1649).

Becker v. Weinberg Group, Inc. Pension Trust, *supra*, 473 F. Supp. 2d at 69. The court elaborated on its reasoning as follows:

> PBGC's obligation to issue a notice of noncompliance is triggered only "if it determines" one of the several listed factors applies. This language provides PBGC with a subjective standard whose application cannot be reviewed by this Court.

> PBGC's decision not to audit or issue a notice of noncompliance is analogous [sic] the exercise of "prosecutorial discretion" discussed in *Chaney*. Its discretion to not act in this case is a "single-shot nonenforcement decision," i.e., "an agency's decision to decline enforcement in the context of an individual case," and is unreviewable.

Becker v. Weinberg Group, Inc. Pension Trust, *supra*, 473 F. Supp. 2d at 69-70 (quoting Crowley Caribbean Transport, Inc. v. Pena, 37 F.3d 671, 676 (D.C. Cir. 1994)).

The case *sub judice* involves a similar discretionary trigger[307] for PBGC action, set forth in 29 U.S.C. § 1342(c)(1): "(1) If the corporation…**has determined** that the plan **should be terminated**…" (emphasis supplied). The determination whether the plan "should be terminated" is for *PBGC* to make, and the statute provides no criteria a court could employ to evaluate whether PBGC has acted correctly. Accordingly, as in Becker v. Weinberg Group, Inc. Pension Trust, "[t]his language provides PBGC with a subjective standard whose application cannot be reviewed by this Court." Becker, *supra*, 473 F. Supp. 2d at 70. See also Paulsen v. CNF Inc., *supra*, 559 F.3d at 1086-87 ("There is no 'meaningful standard' against which to judge PBGC's decision not to act."). Thus, PBGC's failure to terminate a plan under sub-sections (1) – (4) is not judicially reviewable. Consequently, PBGC cannot be required to join this lawsuit as a plaintiff, or compelled to terminate the Plan.

The Prospect Entities contend otherwise, however, and argue that the Court can compel a plan termination, and that PBGC's decision not to do so will be subject to *de novo* review by the Court. Prospect Memo. at 17. Their entire argument is worth quoting, if only to see it *in toto* before it is dismantled:

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[307] The arguably mandatory trigger set forth in 29 U.S.C. § 1342(c)(1), which applies when PBGC determines that a plan is currently failing to pay benefits when due, is not applicable here because the Plan is continuing to make payments when due.

> In the unlikely event that the PBGC attempts to delay or avoid its responsibilities, despite the clear statutory role that Congress has assigned to it, this Court could decide the issue *de novo*, and if termination of the Plan is found to be necessary, force the issue by deciding the Plan's termination date in accordance with ERISA § 4048(a)(4) [29 U.S.C. § 1348(a)(4)]. See, e.g., *In re UAL Corp.*, 468 F.3d 444 (7th Cir. 2005); see also *PBGC v. Heppenstall Co.*, 633 F.2d 293 (3rd Cir. 1980); *PBGC v. St. Gobain Corp. Benefits Comm.*, 2013 U.S. Dist. LEXIS 144515 (E.D. Pa. Oct. 4, 2013) (outlining the administrative process the PBGC follows when determining when and whether to initiative involuntary termination proceedings, and concluding that in the absence of action by the PBGC, the court can decide the issue *de novo*).
>
> While the PBGC could be expected to contend that this Court would need to defer to PBGC's own determinations, likely applying an abuse of discretion standard generally reserved for agency actions taken under the Administrative Procedures Act (the "APA"), *Atieh v. Riordan*, 797 F.3d 135, 138 (1st. Cir. 2015) (courts may set aside an agency's decision if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law."); *Dycus v. PBGC*, 133 F.3d 1367, 1369 (10th Cir. 1998) (recognizing review framework applies to decisions made by the PBGC), that contention should not hold sway. Courts have found that inaction—or here, a non-decision—does not implicate the APA or trigger the prescribed deferential standard. *St. Gobain Corp. Benefits Comm.*, 2013 U.S. Dist. LEXIS 144515, at *9-12. And while the issue is not (and likely never will be) before the Court, it should be noted that based on the statutory directives and the PBGC's past practices, any decision by the PBGC not to initiate termination proceedings and pay Plan benefits, despite its dire financial condition, would likely constitute an abuse of discretion.[10] [308]

Prospect Memo. at 17-18.

We submit that the Prospect Entities are simply inviting the Court down the primrose path, with no case law for cover. In short, all of the cases upon which they rely concern the scope of judicial review *after* PBGC exercises it enforcement or

[308] The Prospect Entities' footnote 10 is discussed below.

adjudicative authority, and none even remotely impinge on PBGC's discretion *not to exercise* its enforcement discretion. Thus, contrary to the Prospect Entities' speculation that PBGC would argue for an abuse of discretion standard, it must be assumed PBGC would argue that its non-enforcement decisions are subject to no judicial review whatsoever, regardless of the standard.

In their argument the Prospect Entities cite three cases in which PBGC exercised its statutory right to seek an involuntary termination by commencing litigation in the United States District Court to obtain that relief,[309] and the courts held that, by statute, the court and not PBGC determines whether the plan should be terminated and the date, because in that context PBGC was merely a litigant. See In re UAL Corp., 468 F.3d 449 (7th Cir. 2005) ("All the PBGC had done is commence litigation, and its position is no more entitled to control than is the view of the Antitrust Division when the Department of Justice files suit under the Sherman Act. As the plaintiff, a federal agency bears the same burden of persuasion as any other litigant.") (citation omitted); PBGC v. Heppenstall Co., 633 F.2d 293, 301 (3rd Cir. 1980) ("PBGC suggests that we should determine that as a matter of law December 18, 1978, was the appropriate date. Its principal argument is that the court should accede to its administrative expertise as to when a plan should be terminated. But while PBGC's views on a date obviously should be accorded fair consideration, the statutory scheme relegates resolution of disputes over termination to the court in the first instance, not to PBGC."); Pension Ben. Guar.

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[309] See 29 U.S.C. § 1342(c)(1) ("If the corporation is required under subsection (a) of this section to commence proceedings under this section with respect to a plan or, after issuing a notice under this section to a plan administrator, has determined that the plan should be terminated, it may, upon notice to the plan administrator, **apply to the appropriate United States district court for a decree adjudicating that the plan must be terminated**. . . .").

Corp. v. Saint-Gobain Corp. Benefits Comm., No. CIV.A. 13-2069, 2013 WL 5525693, at *8 (E.D. Pa. Oct. 4, 2013) ("Although the Third Circuit has not addressed the standard of review issue for an involuntary termination, these cases suggest that the Court would not have reviewed PBGC's determination that a plan should be terminated under the "arbitrary and capricious" standard. Rather, the language in the above two cases supports this Court's conclusion that, absent an agreement between PBGC and the plan administrator, a district court should come to its own determination that a pension plan should be terminated.").

None of these cases remotely support the proposition that a court can compel PBGC to seek an involuntary termination, any more than the fact that in a criminal trial the prosecutor is treated as a litigant who must prove his or her case means that a court can compel a prosecutor to seek an indictment.

The Prospect Entities next cite Atieh v. Riordan, 797 F.3d 135 (1st. Cir. 2015) for the proposition that "courts may set aside an agency's decision if it is 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.'" Prospect Memo. at 17 (quoting Atieh v. Riordan, supra, 797 F.3d at 138). The plaintiff in that case brought suit in the United States District Court to review a decision of Board of Immigration Appeals pursuant to the provisions of the Administrative Procedure Act, 5 U.S.C. §§ 701–706, for judicial review of final agency decisions. Atieh v. Riordan, supra, 797 F.3d at 136. Again, this has nothing to do with the issue of PBGC's (or any agency's) discretion not to exercise its enforcement powers.

The next case, Dycus v. PBGC, 133 F.3d 1367, 1369 (10th Cir. 1998), is a case in which PBGC assumed administration of pension plans after they had been voluntarily

terminated, and involved PBGC's determination in its capacity as trustee of the plan to deny plan participants' application for early termination benefits. Again, it also has nothing to do with the issue of PBGC's (or any agency's) discretion not to exercise its enforcement powers.

The Prospect Entities add a footnote to support their erroneous argument that "while the issue is not (and likely never will be) before the Court, it should be noted that based on the statutory directives and the PBGC's past practices, any decision by the PBGC not to initiate termination proceedings and pay Plan benefits, despite its dire financial condition, would likely constitute an abuse of discretion."). Prospect Memo. at 17). That footnote states that "[t]he PBGC has previously provided benefits in connection with non-electing church plans that have fallen from grace, as well as plans that previously were subject to ERISA (and PBGC protection) but subsequently became church plans and then became insolvent. See, e.g., PBGC May 10, 2003 Release (Hospital Center at Orange), found at https://www.pbgc.gov/news/press/releases/pr13-10."). Prospect Memo. at 17 n.10. Again, actions taken by PBGC pursuant to its enforcement authority have absolutely nothing to do with whether PBGC can be judicially compelled to exercise its enforcement authority.

(G) PBGC's Role Is Too Speculative to be Considered

Although Plaintiffs assert that the Plan is covered by ERISA, Plaintiffs also candidly recognize that it may not be.[310] Defendants' claim that the Plan participants

[310] In cases in which the applicability of ERISA is disputed, there is "good reason for alternatively pleading state and federal claims." Coleman v. Standard Life Ins. Co., 288 F. Supp. 2d 1116, 1120 (E.D. Cal. 2003) ("If the plaintiff brings only state law claims and the court determines there is an ERISA plan, the

may rely upon PBGC's guarantee is based upon certain assumptions of future events: that 1) the Plan will be covered under ERISA at the time is terminated; 2) PBGC's current level of coverage will continue; 3) PBGC will remain in existence in its current form; and 4) PBGC will have the funds necessary to pay the required benefits. All of these assumptions are speculative and problematic.

The consequences for the Plan participants likely would be severe if the Receiver terminated the Plan and it was subsequently determined that there was no PBGC coverage, either because any of these assumptions did not materialize or for any other reason. According to the Angell report attached to the Petition for Appointment of a Temporary Receiver, if the Plan were terminated, the current assets of the Plan would be sufficient to fund merely 60% of the benefits due to the approximately 1,300 retirees currently receiving benefits, with nothing for the remaining (approximately 1,440) Plan participants. To protect the Plan participants from that dire outcome, the Receiver has taken the sensible course of maintaining the Plan while taking all possible steps to secure its solvency, including bringing this lawsuit.

It is the speculative nature of future third party payments, including benefit programs, that makes future benefits inadmissible to mitigate damages. Joerg v. State Farm Mut. Auto. Ins. Co., 176 So.3d 1247, 1254 (Fla. 2015) ("[I]t is absolutely

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state law claims are preempted. But if the plaintiff brings only an ERISA claim and the plan turns out not to be an ERISA plan, the plaintiff is also out of luck. Thus, ERISA preemption often presents the sort of situation for which Rule 8's alternative pleading provision is designed.").

In addition to asserting alternative state law claims in this case, Plaintiffs have commenced an action in state court that is essentially identical to this case, except that it does not assert any claims under ERISA. That action was commenced in the event the Court determines that ERISA is inapplicable and chooses not to exercise supplementary jurisdiction over Plaintiffs' state law claims. That case is stayed pending the resolution of this case.

speculative to attempt to calculate damage awards based on benefits that a plaintiff has not yet received and may never receive, should either the plaintiff's eligibility or the benefits themselves become insufficient or cease to continue.") (excluding evidence of social legislation benefits to mitigate damages).

Such future benefits are inadmissible even when funded by public revenues. Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987) ("All public programs exist subject to legislative approval. While some programs maintain more stability than others, injured plaintiffs cannot count on their continued availability."). As poetically described in Cates:

> To encourage juries to mitigate damages based on tenuous public resources forces plaintiffs, like the foolish house builder in the parable, to rebuild lives on shifting sands. The floods may come, and the winds blow, and great will be the fall.

Id. at 739.

As noted above, PBGC is dependent upon having sufficient income from premiums and other private resources which place it at even higher risk than programs funded from general tax revenues. See GAO 3-17-317 at 615 ("Absent additional steps to improve PBGC's finances, the long-term financial stability of the agency remain uncertain and the retirement benefits of millions of American workers and retirees could be at risk of dramatic reductions.").

(H) At Most, PBGC Would Be a Possible Future Collateral Source

At most, PBGC is a possible prospective collateral source of recovery for the Plan participants. Accordingly, possible PBGC coverage does not detract from the Plan participants' injury in fact, because the collateral source rule requires that it be disregarded in determining whether Plaintiffs have constitutional standing.

A "collateral source" is compensation already received by the plaintiff from a different source when this source is collateral to the defendant. Chisholm v. UHP Projects, Inc., 205 F.3d 731, 737 (4th Cir. 2000) ("The 'collateral source rule' prevents the defendant from claiming an offset from compensation already received by the plaintiff from a different source when this source is collateral to the defendant."). Evidence that the injured party has been compensated by a collateral source is prohibited by the collateral source rule. Hartnett v. Reiss S.S. Co., 421 F.2d 1011, 1016 n.3 (2d Cir. 1970) ("The general rule in the federal courts is that the collateral source rule is applied and defendants cannot show payments of this kind in mitigation.").

"The collateral source rule readily applies in the ERISA context." Beta Grp., Inc. v. Steiker, Greenaple, & Croscut, P.C., No. CV 15-213 WES, 2018 WL 461097, at *3 (D.R.I. Jan. 18, 2018) (Smith, C.J.). As the Court held In Beta Group, Inc.,

> The collateral source rule readily applies in the ERISA context. See, e.g., Merriam v. Demoulas, No. 11–10577–RWZ, 2013 WL 2422789, at *3 (D. Mass. June 3, 2013). To this end, courts have recognized that payments made by a fiduciary or plan sponsor to correct errors connected to the operation of an ERISA-governed plan do not rescind or set off fiduciaries' capacity to recover from actual wrongdoers. See Chao v. Merino, 452 F.3d 174, 184–85 (2d Cir. 2006); Merriam, 2013 WL 2422789, at *3; In re State St. Bank & Tr. Co. ERISA Litig., 579 F. Supp. 2d 512, 517 (S.D.N.Y. 2008).

Beta Group, Inc., *supra*, 2018 WL 461097, at *3 (citing Chao v. Merino, 452 F.3d 174, 184–85 (2d Cir. 2006), Merriam v. Demoulas, No. CIV.A. 11-10577-RWZ, 2013 WL 2422789, at *3 (D. Mass. June 3, 2013), and In re State St. Bank & Tr. Co. ERISA Litig., 579 F. Supp. 2d 512, 517 (S.D.N.Y. 2008)).

The consequence is that collateral sources of recovery are *not* considered in determining a plaintiff's injury in fact for purposes of constitutional standing. This has been held in a number of ERISA cases, as well as cases outside of ERISA.[311] The ERISA cases include the Court's decision in Beta Group, Inc., *supra*, in which the Court accepted the report and recommendation of Magistrate Judge Almond that applied the collateral source rule to reject the defendants' claims that the plaintiffs had suffered no cognizable injury because they had been fully compensated for their losses. See Beta Group, Inc., *supra*, 2018 WL 461097, at *3 ("Accordingly, the Court ACCEPTS the R&R (ECF No. 54) in its entirety and adopts its reasoning and recommendations."). The Magistrate Judge wrote:

> Thus, the narrow issue before the Court at the dismissal stage is whether the Plan and its Trustee have alleged a cognizable injury. Based on the allegations contained in the Amended Complaint, I find that Plaintiffs have alleged a cognizable injury, and decline to dismiss the Plan and Mr. Romeo as Plaintiffs at this time. In a relatively recent case from the District of Massachusetts, the defendant argued that "even if the collateral source rule is generally applicable in ERISA cases, it should not apply here

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[311] The principle that collateral sources of recovery are irrelevant to the standing inquiry is by no means unique to ERISA cases. See Rideau v. Keller Independent School Dist., 819 F.3d 155 (5th Cir. 2016) ("For the reasons explained more fully below, the existence of a potential third-party payor in the form of the Trust does not deprive the Rideaus of standing that would otherwise exist as a result of incurring that obligation…"); Markva v. Haveman, 168 F. Supp. 2d 695 (E.D. Mich. 2001) ("The defendants have cited no authority to suggest that the Court may or should look to a collateral source when determining whether a party has suffered an injury in fact."); Muzuco v. Re$ubmitIt, LLC, 297 F.R.D. 504 (S.D. Fla. 2013) ("The Defendants have cited no authority to suggest that the Court should look to recovery from a third-party when determining whether a party has suffered an injury in fact. Instead, recovery from a third-party is typically addressed by the collateral source rule, an evidentiary rule that governs the introduction of evidence of payments from collateral sources. Payments or reimbursements received from a collateral source are irrelevant to standing here.") (citation omitted); Garner Properties & Mgmt. v. Charter Twp. of Redford, No. 15-14100, 2017 WL 3412080, at *3 (E.D. Mich. Aug. 8, 2017) ("Moreover, upon its own review of governing case law, the Court concludes that Garner Properties does not lack standing... '[W]hen the victim of a tort receives payment for his injuries from a collateral source, that is, a source independent of the tortfeasor, the payment should not be deducted from the damages owed by the tortfeasor.'… [W]hether Garner Properties has a means to offset its alleged losses from some other, wholly independent source is irrelevant. Redford's standing argument is rejected.") (quoting Ward v. Allied Van Lines, Inc., 231 F.3d 135, 139 (4th Cir. 2000)) (other citations omitted).

> because it would provide the Plan a double recovery," the District Court rejected that argument, and noted that, "the entire point of the collateral source rule is that a double recovery for the injured plaintiff is better than a windfall for the tortfeasor."

Beta Grp., Inc., *supra*, 2018 WL 461097, at *11 (Almond, U.S.M.J.) (quoting Merriam v. Demoulas, 2013 WL 2422789, at *3).

Similarly, Merriam v. Demoulas, *supra*, is another ERISA case in which the court relied upon the collateral source rule and held that plan participants had suffered the constitutionally required injury in fact and were entitled to sue for $46 million in losses to plan assets caused by the plan trustees' breach of fiduciary duty, even though the plan sponsor had reimbursed the plan in full for the loss. Merriam v. Demoulas, *supra*, 2013 WL 2422789, at *3 ("In summary, plaintiffs have suffered a cognizable injury in fact even if they have been made whole by a third party. Their complaint is not subject to dismissal on this basis.").

In re State St. Bank & Tr. Co. ERISA Litig., 579 F. Supp. 2d 512 (S.D.N.Y. 2008) is another ERISA case in which the court held that the plaintiffs' receipt from a third party of full compensation for their losses after filing suit did not deprive the plaintiffs of a "legally cognizable injury." In re State St. Bank & Tr. Co. ERISA Litig., *supra*, 579 F. Supp. 2d at 517 ("The premise of State Street's motions—that an action is necessarily mooted when a plaintiff's damages are reimbursed—is flawed. Federal courts regularly apply the 'collateral source rule,' which permits a plaintiff to recover damages from a tortfeasor though the plaintiff has already received compensation for its injuries from a third-party and even when such an award would lead to double recovery.").

The collateral source rule applies even if plaintiffs obtain a double recovery as a consequence, because that is preferable to allowing the defendants to gain a windfall by

avoiding liability. See Merriam v. Demoulas, *supra*, 2013 WL 2422789, at *3 ("But the entire point of the collateral source rule is that a double recovery for the injured plaintiff is better than a windfall for the tortfeasor.") (citing 22 Am. Jur. 2d Damages § 392). However, there is no risk of double recovery here. There is no scenario under which the Plan participants will receive double benefits. The Plan is, after all, a defined benefit plan, with no provision for payments in excess of the defined benefits. Accordingly, there is even more reason to apply the collateral source rule to exclude consideration of PBGC's guarantee.

Our case is similar in that sense to In re State St. Bank & Tr. Co. ERISA Litig., *supra*, in which application of collateral source rule also did not result in a double recovery. That fact made application of the collateral source rule "particularly appropriate" according to the court in In re State Street Bank:

> **In fact, application of the collateral source rule is particularly appropriate in this case**…. Furthermore, because the terms of the Loans require the Plans to repay Prudential the Loan amount from any recovery obtained in this litigation, there is no threat of double recovery in this case.

In re State St. Bank & Tr. Co. ERISA Litig., *supra*, 579 F. Supp. 2d at 518-19 (emphasis supplied).

Moreover, not reducing the Plan participant's recovery for anticipated benefits from PBGC has the additional benefit of preserving PBGC's limited assets to pay benefits to participants in other plans upon default, since to the extent there is recovery from the Defendants, any need for payments from PBGC will be reduced.

These ERISA cases all stand for the proposition that collateral sources of present or future recovery do not affect constitutional standing. The Plan participants' constitutional standing, including specifically their injuries in fact, is not affected by the

speculative possibility that someday they may be entitled to coverage by PBGC's guarantee.

B. Plaintiffs' Claims Are Ripe for Adjudication

1. The Standard for Ripeness

The ripeness doctrine is intended to "prevent the adjudication of claims relating to 'contingent future events that may not occur as anticipated, or indeed may not occur at all.'" Reddy v. Foster, 845 F.3d 493, 500 (1st Cir. 2017) (quoting Thomas v. Union Carbide Agric. Prods. Co., 473 U.S. 568, 580-81 (1985)). To be ripe, a complaint must "show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of the judicial relief sought." Reddy, 845 F.3d at 500 (quotation marks and citations omitted).

Ripeness analysis has two prongs: fitness and hardship. Texas v. United States, 523 U.S. 296, 301 (1998). "The fitness prong 'has both jurisdictional and prudential components.'" Reddy, 845 F.3d at 501 (quoting Roman Catholic Bishop of Springfield v. City of Springfield, 724 F.3d 78, 89 (1st Cir. 2013)). "The jurisdictional component ... concerns 'whether there is a sufficiently live case or controversy, at the time of the proceedings, to create jurisdiction in the federal courts.'" Id. "The prudential component . . . concerns whether 'whether resolution of the dispute should be postponed in the name of 'judicial restraint from unnecessary decision of constitutional issues.'" Id.

By contrast, the hardship prong is wholly prudential, and requires that a plaintiff show that he will "suffer [direct and immediate harm] from withholding of a decision." McInnis-Miesnor v. Maine Med. Ctr., 319 F.3d 63, 73 (1st Cir. 2003). However, the Supreme Court has "cast a measure of doubt upon ripeness's prudential dimensions,

observing that prudential justiciability doctrines, including ripeness, are 'in some tension with . . . the principle that a federal court's obligation to hear and decide cases within its jurisdiction is virtually unflagging.'" Reddy, *supra*, 845 F.3d. at 501 n.6 (quoting Susan B. Anthony List v. Driehaus, 134 S.Ct. at 2347 and Lexmark Int'l, Inc. v. Static Control Components, Inc., 134 S.Ct. 1377, 1386 (2014)). See also Wright & Miller at al., Federal Practice and Procedure: Civil 3d § 3531 ("The long-settled view that a court may deny standing for prudential reasons even though Article III requirements are met may be coming into question. The Court has suggested that added prudential requirements of standing and ripeness are 'in some tension' with the theory that a federal court has a virtually unflagging obligation to decide a case in its jurisdiction.") (quoting Susan B. Anthony List v. Driehaus, *supra*, 134 S.Ct. at 2347).

2. Plaintiffs' Claims Are Ripe

The events that led to this lawsuit, as recited in the Complaint and the Receivership Petition, demonstrate beyond any reasonable dispute that this case involves "a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of the judicial relief sought." Defendant SJHSRI put the Plan into receivership, with a request that the state court cut benefits by 40% across the board, and the representation that, "absent judicial intervention" by the receivership court, SJHSRI was considering an immediate termination of the Plan, under which "beneficiaries currently receiving benefits would receive a payout of approximately 60% of their accrued benefits and all other beneficiaries would receive no distributions whatsoever." In other words, from that

moment, the Plan participants were and are on the verge of disaster, and this lawsuit can save them.

Under these circumstances, it is not only clearly true but it is also a gross understatement to assert that the concerns of the Receiver and the Plan participants have "sufficient immediacy and reality to warrant the issuance of the judicial relief sought." Therefore, Plaintiffs' claims are certainly ripe.

C. PBGC Is Not an "Indispensable Party"

The Defendants also seek dismissal of Plaintiffs' claims on the grounds that the Plaintiffs, by failing to sue PBGC, have failed to join an allegedly "indispensable party." Prospect Entities' Memo at 19 ("Even if Plaintiffs' ERISA claims are sufficiently ripe, the Court should dismiss the Amended Complaint for failure to join the PBGC as an indispensable party or, in the alternative, the Court should join the PBGC as a necessary party under Rule 19(a)."); Angell Memo. at 13 ("Accordingly, the FAC should be dismissed pursuant to Fed. R. Civ. P. 12(b)(7) for failure to join an indispensable party – the PBGC.").

However, the Federal Rules have not referred to a motion to dismiss "for failure to join an indispensable party" since 1966, when the rule was amended to delete the term "an indispensable party" and re-written to refer to "failure to join a party under Rule 19." See Wright & Miller, Federal Practice and Procedure: Civil 3d § 1359 (setting forth the history of Rule 12(b)(7)).

Defendants' error is not merely a technical mislabeling of a motion to dismiss. Rule 19 by its express terms allows for dismissal only if the absent party 1) cannot feasibly be joined, and 2) the court determines that in equity and good conscience the

action cannot proceed without the missing party. Thus, if the missing party can be joined, an action cannot be dismissed for failure to include that party in the lawsuit. See Boone v. General Motors Acceptance Corp., 682 F.2d 552, 553–54 (5th Cir. 1982) (holding that dismissal for non-joinder is improper if the absent party is subject to impleader).

There is no dispute over the fact that PBGC could be sued in Rhode Island, where the Plan has its principal office. By statute, PBGC is subject to suit in an "appropriate court," which is defined to include "(A) the United States district court before which proceedings under section 1341 or 1342 of this title are being conducted, (B) if no such proceedings are being conducted, the United States district court for the judicial district in which the plan has its principal office, or (C) the United States District Court for the District of Columbia." 29 U.S.C. § 1303(f)(2). Thus, under no circumstances are the Defendants entitled to dismiss Plaintiffs' claims based upon Fed. R. Civ. P. 12(b)(7) for failure to join a party under Rule 19.

D. PBGC Should Not Be Subjected to Compulsory Joinder

Likely in recognition that their claims for dismissal based upon the absence of PBGC are completely unwarranted, Defendants request, as an alternative remedy, that the Court order that PBGC be joined in this proceeding. See Prospect Entities' Memo at 19 ("[T]he Court should dismiss the Complaint for failure to join the PBGC as an indispensable party or, in the alternative, the Court should join the PBGC as a necessary party under Rule 19(a)."); Angell Memo. at 52 ("Moreover, to the extent Plaintiffs bring this claim pursuant to the Rhode Island Declaratory Judgment Act

(‘RIDJA’)[312], then the PBGC must be joined as a party to this action.”); Diocesan Defendants’ Memo. at 7 (“Assuming the Court agrees that the PBGC is an indispensable party, the Court should order Plaintiffs to join the PBGC in these proceedings and, to the extent joinder is either impossible or impracticable, dismiss this action.”). That argument also should be summarily rejected.

1. Standard for Compulsory Joinder

Fed. R. Civ. P. 19(a) sets forth the requirements for compulsory joinder:

> (a) Persons Required to Be Joined if Feasible.
>
> (1) Required Party. 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.

Thus:

> Rule 19(a) is applicable when nonjoinder would have either of the following effects. First, it would prevent complete relief from being accorded among those who are parties to the action or, second, the absentee “claims an interest relating to the subject matter of the action

[312] None of the claims in this lawsuit are brought pursuant to the Rhode Island Declaratory Judgment Act.

> and is so situated" that the nonparty's absence from the action will have a prejudicial effect on that person's ability to protect that interest or will "leave any of the persons already parties subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations."

Wright, Miller & Kane, Federal Practice and Procedure: Civil 3d § 1604 (citations omitted).

"When making that determination, the court must base its decision on the pleadings as they appear at the time of the proposed joinder. . . ." Id. (citations omitted). Defendants have chosen to file motions to dismiss rather than answer the complaint. Thus, the decision must be based upon the allegations of the complaint, without consideration of Defendants' possible answers thereto, affirmative defenses, counter-claims, cross-claims, or third party claims. See Associated Dry Goods Corp. v. Towers Financial Corp., 920 F.2d 1121, 1124 (2d Cir. 1990) ("It is troubling that the district court reached its conclusion by considering Towers' 'putative answer' and proposed, but not yet pled, third-party claims. Indeed, it is the general rule that a court considering 'whether [an] absent person's interest in the litigation is sufficient to satisfy ... the first sentence of Rule 19(a) . . . must base its decision on the pleadings as they appear at the time of the proposed joinder.'") (quoting Wright, Miller & Kane, Federal Practice and Procedure: Civil 3d § 1604).

"A plaintiff ordinarily is free to decide who shall be parties to his lawsuit." Simpson v. Alaska State Com'n for Human Rights, 608 F.2d 1171, 1174 (9th Cir. 1979). "As a general rule, plaintiffs are entitled to decide who shall be included as parties to a litigation. Thus, compulsory joinder of a party is an exception to the general practice and should be ordered only where significant countervailing considerations make the joinder of particular absentees desirable." Generadora De Electricidad Del Caribe, Inc. v.

Foster Wheeler Corp., 92 F. Supp. 2d 8, 14 (D.P.R. 2000) (citing Wright, Miller & Kane, Federal Practice and Procedure: Civil 3d § 1602). See also Ford Motor Credit Co. v. Beard, 45 F.R.D. 523, 525 (D.S.C. 1968) ("However, it is within the Court's discretion to determine if one is a necessary party to a suit, and such discretion must take cognizance of the fact that compulsory joinder of parties is an exception to the usual practice which permits plaintiffs to decide who shall become parties to a law suit.").

Moreover, if the defendant is capable of bringing into the litigation a nonparty whose presence is allegedly required to fully resolve the controversy, and if that nonparty is otherwise capable of intervening, then the burden of bringing in the nonparty is on the defendant and the nonparty, and the nonparty is not subject to compulsory joinder under Rule 19(b). Thunder Basin Coal Co. v. Southwestern Public Service Co., 104 F.3d 1205, 1211 (10th Cir. 1997) ("Underlying the Seventh Circuit's decision is this proposition: if the defendant is capable of bringing into the litigation a nonparty whose presence is allegedly required to fully resolve the controversy and if that nonparty is otherwise capable of intervening, then the nonparty cannot be considered indispensable under Rule 19(b).") (citing with approval Pasco Int'l (London) Ltd. v. Stenograph Corp., 637 F.2d 496, 503 (7th Cir. 1980)) (other citations omitted).

"'[C]omplete relief refers only to relief as between the persons already parties, and not as between a party and the absent person whose joinder is sought.'" Socci v. JPMorgan Chase & Co., No. 217CV5469DRHAYS, 2018 WL 4388454, at *4 (E.D.N.Y. Sept. 14, 2018) (quoting Arkwright-Boston Mfrs. Mut. Ins. Co. v. City of New York, 762 F.2d 205, 209 (2d Cir. 1985)); Incubadora Mexicana, SA de CV v. Zoetis, Inc., 310 F.R.D. 166, 171 (E.D. Pa. 2015) ("Rule 19(a)(1) is limited to whether the district court

may grant complete relief to those already parties); Snodgrass-King Pediatric Dental Associates, P.C. v. DentaQuest USA Ins. Co., Inc., 79 F. Supp. 3d 753, 771 (M.D. Tenn. 2015) (issue of complete relief decided based on existing parties).

With respect to the second prerequisite for compulsory joinder, *i.e.* that the absent party "claims an interest relating to the subject of the action," the movant must demonstrate that the absent party *actually* claims an interest, not merely that the absent party *might* claim an interest, or that the movant would be entitled to assert an interest on behalf of the absent party. Peregrine Myanmar Ltd. v. Segal, 89 F.3d 41, 49 (2d Cir. 1996) ("As to the second part of Rule 19(a), Segal's argument fails here if only because the Ministry has not 'claim[ed] an interest relating to the subject of the action.' Segal's attempt to assert on behalf of the Ministry its supposed concern about the dilution of its interest in MAFCO falls outside the language of the rule. It is the absent party that must 'claim an interest.'") (quoting Fed. R. Civ. P. 19(a)(1)(B)).

In short, the absent party is the best judge of its own interests, and its choice not to intervene should not be second guessed without good reason. As the First Circuit stated in U.S. v. San Juan Bay Marina, 239 F.3d 400, 406-407 (1st Cir. 2001):

> We add that the Commonwealth, well aware of this situation, never moved to intervene, and so it is apparently of the view that its interests either were not at stake or were aligned with those of the United States. Cf. Fed.R.Civ.P. 19(a)(2) (compulsory joinder appropriate where the person "claims an interest" relating to the subject of the action that is threatened by litigation in his absence) (emphasis added). Since its decision to forgo intervention indicates that the Commonwealth does not deem its own interests substantially threatened by the litigation, the court should not second-guess this determination, at least absent special circumstances.

U.S. v. San Juan Bay Marina, *supra*, 239 F.3d at 406-07.

Moreover, for the interest claimed by the absent party to be significant under Rule 19, it must be a "legally protected" interest. U.S. v. San Juan Bay Marina, *supra*, 239 F.3d at 406 ("However, a party is necessary under Rule 19(a) only if they claim a "legally protected interest" relating to the subject matter of the action.") (citing Northrop Corp. v. McDonnell Douglas Corp., 705 F.2d 1030, 1043 (9th Cir. 1983)). A legally protected "interest must be more than a financial stake, and more than speculation about a future event." Cachil Dehe Band of Wintun Indians of the Colusa Indian Community v. California, 547 F.3d 962, 970 (9th Cir. 2008). "Speculation about the occurrence of a future event ordinarily does not render all parties potentially affected by that future event necessary or indispensable parties under Rule 19." Northrop Corp. v. McDonnell Douglas Corp., *supra*, 705 F.2d at 1046.

Under the clear hierarchy and structure of Fed. R. Civ. P. 19(a)(1)(B), it is only after the movant demonstrates that the absent party "claims an interest relating to the subject matter of the action" that it is even relevant whether non-joinder will "leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest" under Fed. R. Civ. P. 19(a)(1)(B)(i). The two elements are conjunctive. In other words, Rule 19 only protects parties from the risk of inconsistent obligations involving nonparties if the non-parties claim a legally protected interest in the subject matter of the action. The mere risk of inconsistent obligations is, therefore, not sufficient for compulsory joinder.

The case law is consistent with the plain meaning of Rule 19. See Marina One, Inc. v. Jones, 29 F. Supp. 3d 669, 678 (E.D. Va. 2014) ("Rule 19(a)(1)(B) has two sub-parts, either of which is sufficient to require joinder, but a prerequisite to both is that Mr.

Jones 'claims an interest relating to the subject of the action.'"); BNP Paribas v. Bank of New York Tr. Co., N.A. No. 11 CIV. 350 (PGG), 2012 WL 13059498, at *12 (S.D.N.Y. Mar. 28, 2012) ("The Second Circuit has made clear that '[s]ubparts (i) and (ii) [of Rule 19(a)(2)[313] are contingent ... upon an initial requirement that the absent party claim a legally protected interest relating to the subject matter of the action.'") (quoting ConnTech Dev. Co. v. Univ. of Connecticut Educ. Properties, Inc., 102 F.3d 677, 682 (2d Cir. 1996)); Halsne v. Avera Health, No. CV 12-2409 (SRN/JJG), 2013 WL 12151523, at *4 (D. Minn. Feb. 14, 2013) ("Turning to Rule 19(a)(1)(B), PCMC simply has not claimed an interest in the subject matter or the outcome of this case, financial or otherwise. Avera Health overlooks this initial requirement of Rule 19(a)(1)(B) and argues that, without the addition of PCMC, Avera Health will be 'subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations,' Fed. R. Civ. P. 19(a)(1)(B)(ii). But this consideration is in addition to, not in the alternative to, the requirement that the person to be joined must claim an interest in the subject matter of the action. *See id.* (requiring the person to be joined to be one who 'claims an interest relating to the subject of the action'). Consequently, PCMC is not a necessary party under Rule 19(a)(1)(B).").

Moreover, it must be emphasized that Rule 19 refers to "inconsistent obligations" which is a much narrower basis for compulsory joinder than "inconsistent results":

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[313] Prior to 2007, current Rule 19(a)(1)(B) was Rule 19(a)(2). See Hartford Casualty Ins. Co. v. Cardenas, 292 F.R.D. 235 , 242 (E.D. Pa. 2013) (referring to "what was then Rule 19(a)(2), and now Rule 19(a)(1)(B)…."); 2007 Advisory Committee Note to Rule 19 ("The language of Rule 19 has been amended as part of the general restyling of the Civil Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only.").

> "Inconsistent obligations" are not, however, the same as inconsistent adjudications or results. Inconsistent obligations occur when a party is unable to comply with one court's order without breaching another court's order concerning the same incident. Inconsistent adjudications or results, by contrast, occur when a defendant successfully defends a claim in one forum, yet loses on another claim arising from the same incident in another forum. ….Unlike a risk of inconsistent obligations, a risk that a defendant who has successfully defended against a party may be found liable to another party in a subsequent action arising from the same incident—i.e., a risk of inconsistent adjudications or results—does not necessitate joinder of all of the parties into one action pursuant to Fed.R.Civ.P. 19(a).

Delgado v. Plaza Las Americas, Inc., 139 F.3d 1, 3 (1st Cir. 1998) (citations omitted).

2. Plaintiffs Have No Claim Against PBGC

Plaintiffs cannot be expected to sue PBGC if Plaintiffs presently have no claims against PBGC. Claims against PBGC are controlled by 29 U.S.C. § 1303(h), which states as follows:

> Except with respect to withdrawal liability disputes under part 1 of subtitle E, any person who is a plan sponsor, fiduciary, employer, contributing sponsor, member of a contributing sponsor's controlled group, participant, or beneficiary, **and is adversely affected by any action of the corporation [i.e. PBGC] with respect to a plan** in which such person has an interest, or who is an employee organization representing such a participant or beneficiary so adversely affected for purposes of collective bargaining with respect to such plan, may bring an action against the corporation for appropriate equitable relief in the appropriate court.

(Emphasis supplied). PBGC has taken no action with respect to the Plan. Accordingly, PBGC cannot be joined as a Defendant.

3. Joinder under Rule 19(a)(1)(A) Is Foreclosed Because Nonjoinder Will Not Prevent Complete Relief Between the Parties

The first issue is whether "in [PBGC]'s absence complete relief cannot be accorded among those already parties."

The Prospect Entities state:

> As to Rule 19(a)(1)(A), the Court cannot award complete relief against the existing parties with respect to the heart of Plaintiffs' ERISA claims—the alleged failure to comply with ERISA's minimum funding standards—in the absence of the PBGC, because the PBGC has a critical role to play in the enforcement of those standards and its absence increases exponentially the likelihood of ineffective enforcement and inconsistent results. See, e.g., 29 U.S.C. §§ 1083(k)(4), (k)(5) (creation, enforcement and release statutory liens for failure to satisfy ERISA's minimum funding requirements); see also *LTV Corp.*, 496 U.S. at 637 (describing PBGC's pivotal role in dealing with underfunded defined benefit plans). Thus, to the extent the alleged ERISA minimum funding issues are to be litigated, they cannot reasonably be enforced, or resolved, without the PBGC's active involvement.

Prospect Entities' Memo. at 20.

Although in sequence, the two statements 1) that "the Court cannot award complete relief," and 2) "because the PBGC has a critical role to play in the enforcement of those standards and its absence increases exponentially the likelihood of ineffective enforcement and inconsistent results," are not logically connected. PBGC's alleged "critical role to play" is irrelevant to whether the Court can accord complete relief among the existing parties. "'[C]omplete relief refers only to relief as between the persons already parties, and not as between a party and the absent person whose joinder is sought.'" Socci v. JPMorgan Chase & Co., *supra*, 2018 WL 4388454, at *4) (quoting Arkwright-Boston Mfrs. Mut. Ins. Co. v. City of New York, *supra*, 762 F.2d at 209).

It is clear that the Court's judgments against Defendants and in favor of Plaintiffs can afford the latter complete relief entirely without the presence of PBGC. In that event, the Plan will have sufficient funds to pay benefits, and PBGC will not be involved either because the Plan will not be terminated, or because the Plan will have sufficient funds to meet its termination liabilities without recourse to any PBGC guarantee. Similarly, a defense verdict will accord complete relief among the existing parties. Thus, this is clearly not a case in which "in the [PBGC]'s absence complete relief cannot be accorded among those already parties."

Obviously aware of the illogic of their argument, the Prospect Entities toss into their Rule 19(a)(1)(A) argument the claim that the absence of PBGC "increases exponentially the likelihood of ineffective enforcement and inconsistent results." Prospect Entities' Memo. at 20. That will be addressed in due course, but here it suffices to observe that Rule 19(a)(1)(A) deals only with whether the court can provide complete relief between the parties. The significance of inconsistent obligations is addressed by Rule 19(a)(1)(B).

Angell states:

> 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.

Angell Memo. at 12 (citing Fed. R. Civ. P. 19(a)(1)). As can be seen, Angell does not even address the issue of whether "in [PBGC]'s absence complete relief can be accorded among the existing parties." Instead, its arguments concern factors that are considered under Rule 19(a)(1)(B).

4. Joinder under Rule 19(a)(1)(B) is Foreclosed Because PBGC Does Not Claim a Legally Protected Interest

Rule 19(a)(1)(B) states as follows:

> (a) Persons Required to Be Joined if Feasible.
>
> (1) Required Party. 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:
>
> * * *
>
> (B) the 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.

Fed. R. Civ. P. 19(a)(1)(B) (emphasis supplied). Thus, the threshold and essential requirement for joinder under Rule 19(a)(1)(B) is that the person to be joined "claims an interest relating to the subject of the action."

PBGC does not "claim an interest an interest relating to the subject of the action." As noted in connection with the pending motion to approve the first of two settlements,

the Receiver through Washington counsel [314] has provided PBGC with copies of all complaints, as well as all of the filings in this case and the related state court lawsuits. See Declaration of Jeffrey B. Cohen dated January 16, 2019 ("Cohen Dec.") ¶¶ 4-5.[315] PBGC has not moved to intervene. Accordingly, PBGC does not claim an interest in the subject matter of this action.

PBGC not only does not claim an interest, but indeed the decision of PBGC to decline to assert its statutory right of intervention is discretionary and non-reviewable under Heckler v. Chaney, *supra*, and its progeny. See *supra* at 106-116. Defendants' request that the Court apply Rule 19 to require PBGC to join this proceeding in order to protect PBGC's own interests not only violates Rule 19; it also asks the Court to improperly intrude upon PBGC's enforcement authority.

Moreover, although the Court need not address this issue because PBGC is not claiming an interest, it would appear that any interest in the subject matter that PBGC might assert at this time would not be a legally protected interest. The possibility that PBGC may be called upon to insure benefits sometime in the future, depending on the circumstances at that time, is too speculative to subject PBGC to compulsory joinder.

5. Defendants Are Not Entitled to Compel Joinder of PBGC in Order to Protect Their Interests Against Inconsistent "Results"

Defendants claim that PBGC must be joined to protect their interests against "inconsistent results." Prospect Entities Memo. at 21 ("Not joining the PBGC will expose all parties to a risk of inconsistent results if the PBGC initiates proceedings later."). As

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[314] Jeffrey Cohen, Esq. of Bailey & Ehrenberg. Mr. Cohen was previously Chief Counsel of PBGC.

[315] Dkt. # 83-2 (filed January 21, 2019).

discussed below, Rule 19(a)(1)(B) refers to "inconsistent obligations," of which there is no risk here. However, the Court need not even consider that issue, because, as discussed above, under Fed. R. Civ. P. 19(a)(1)(B), the prerequisite for that issue to be even relevant is that PBGC first must claim a legally protected interest in the subject matter of this action. See Marina One, Inc. v. Jones, *supra*, 29 F. Supp. 3d at 678; BNP Paribas v. Bank of New York Trust Company, N .A., *supra*, 2012 WL 13059498, at *12; Halsne v. Avera Health, *supra*, 2013 WL 12151523, at *4. PBGC claims no interest and therefore it would be irrelevant even if the absence of PBGC exposed Defendants to "inconsistent obligations."

In any event, there is no risk of Defendants having "inconsistent obligations." Defendants are obviously concerned that they may prevail against Plaintiffs yet lose in the same issue in a subsequent suit brought by PBGC, but under that scenario, the Defendants will have *no obligations* to Plaintiffs. All they will have is inconsistent adjudications or results, which do not necessitate joinder under Rule 19:

> "Inconsistent obligations" are not, however, the same as inconsistent adjudications or results. Inconsistent obligations occur when a party is unable to comply with one court's order without breaching another court's order concerning the same incident. Inconsistent adjudications or results, by contrast, occur when a defendant successfully defends a claim in one forum, yet loses on another claim arising from the same incident in another forum. ….Unlike a risk of inconsistent obligations, a risk that a defendant who has successfully defended against a party may be found liable to another party in a subsequent action arising from the same incident—i.e., a risk of inconsistent adjudications or results—does not necessitate joinder of all of the parties into one action pursuant to Fed.R.Civ.P. 19(a).

Delgado v. Plaza Las Americas, Inc., *supra*, 139 F.3d at 3.

The plain meaning of Rule 19 is clear that Defendants' concern over possible inconsistent results or judgments is completely irrelevant, such that there should be no need to even consider the policy implications of Defendants' arguments. However, it should be noted that this principle is also based upon sound policy, because it avoids the catastrophic consequences of requiring joinder of every governmental agency that someday may be required to rule on the same legal issues in a case involving private litigants. The enormous potential breadth of the scope of possible "inconsistent results" or "inconsistent judgments" compared to the scope of "inconsistent obligations," is especially marked in cases involving ERISA, including the specific ERISA issues involved in this case, because of the number of administrative agencies that interpret and apply ERISA in addition to the courts. If joinder were required whenever there is a risk of inconsistent results or judgments, then, whenever the courts are called upon to adjudicate legal and factual disputes involving pension plans which are covered by ERISA, courts would be required to join at least the Department of Labor, PBGC, and the IRS, and in many cases additional federal agencies as well. There are perhaps 10,000 such cases filed in federal court every year.[316]

Such a requirement would make Rule 19 a litigation multiplier/complicator greatly beyond its intended role, and overburden the courts and those agencies. It would also totally eviscerate the principle that a governmental agency's discretionary non-enforcement decisions are not judicially reviewable, since it would require joinder of

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[316] See 2 ERISA Practice and Litigation § 11:1 (citation omitted) ("The Administrative Office of the United States Courts, in its 1992 report, indicated that between 1988 and 1992 the number of ERISA-related suits in the Federal courts increased from 6,884 to 10,918 (59%). As of the turn of the century, ERISA-related filings in the federal courts appear to have plateaued at approximately 10,000 per year.").

federal agencies who had exercised their discretion not to assert claims, either by commencing suit or by intervening in existing cases.

6. Courts Do Not Depend on PBGC to Determine Whether a Pension Plan Qualifies as a Church Plan

There have been literally scores of cases, such as the case *sub judice*, in which plan participants or plan fiduciaries have brought suit alleging that a defined benefit plan was improperly categorized as a "church plan" exempt from ERISA. Those cases seek various forms of relief, including in many instances damages for failing to properly fund the plan in accordance with ERISA. In some of these cases, the plaintiffs allege that their plans were grossly underfunded and the employer lacked the necessary funds to make up the deficit. See, e.g., Thorkelson v. Publ'g House of the Evangelical Lutheran Church in Am., No. CV 10-1712 (MJD/JSM), 2012 WL 12905832, at *12 (D. Minn. Apr. 23, 2012) (pension plan underfunded by $70,000,000, where employer had reserves of only $84,000).

Defendants have failed to cite a single case involving a dispute over church plan status in which it was even argued that PBGC should have been made a party, or in which even permissive joinder of PBGC was considered. We have found no such cases.

Indeed, Defendants have failed to cite a single case, even outside of the church plan context, in which it was even argued that PBGC should have been made a party, or in which even permissive joinder of PBGC was considered. We have found two such cases. The first is distinguishable in that PBGC had taken over the plan and the court based its ruling requiring joinder of PBGC on the grounds that PBGC as plan

administrator would be liable for the judgment. See, e.g., Green v. Eastern Airlines, 138 F.R.D. 146, 148 (M.D. Fla. 1991) ("If the Plaintiff is successful in this action, then the PBGC, **as the Plan administrator**, will be liable for the judgment. Therefore, the Court finds that PBGC is an indispensable party to this action.") (emphasis supplied).

The second case is squarely on point, but directly contradictory to Defendants' argument that PBGC should be compelled to join this case. The case of Paulsen v. CNF Inc., 559 F.3d 1061 (9th Cir. 2009) involved an employer's distress termination of the plan and PBGC taking over as trustee. Paulsen, 559 F.3d at 1071. Suit was brought by employees against a number of defendants, which initially did not include PBGC, but it was argued that PBGC should join the case to assert claims against certain defendants, and so "the District Court ordered the employees to file another amended complaint 'joining Trustee PBGC as a party to the litigation' because PBGC was an indispensable party." Paulsen, 559 F.3d at 1071. Eventually the District Court dismissed the claim against PBGC on the grounds that ERISA did not require PBGC to sue the other defendants, and its decision not to sue the other defendants was "entitled to judicial deference." Paulsen, 559 F.3d at 1071 ("After a hearing, the district court dismissed the Fourth Amended Complaint with prejudice as to PBGC, holding that the breach of fiduciary duty claim was not actionable because 'PBGC's determinations that (1) ERISA did not impose a requirement that PBGC file suit following the failure of the CFC Plan and (2) PBGC had no meritorious claims to assert against Towers on behalf of the plan are entitled to judicial deference.'").

The Ninth Circuit affirmed the District Court's dismissal of the claims against PBGC, but on a different ground than those relied upon by the District Court. The Ninth

Circuit held that PBGC's decision not to sue the other defendants was "not subject to judicial review" at all, based upon Heckler v. Chaney:

> Based on the presumption in *Heckler v. Chaney*, 470 U.S. 821, 105 S.Ct. 1649, 84 L.Ed.2d 714 (1985), we hold that PBGC's discretionary decision not to pursue such claims is not subject to judicial review.

Paulsen v. CNF Inc., *supra*, 559 F.3d at 1071. The court explained its reasoning as follows:

> Turning to the applicability of the *Heckler* presumption here, PBGC retains discretion to sue on behalf of a distress-terminated plan. When PBGC is acting as trustee to a distress terminated plan, it "has the power ... to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan." 29 U.S.C. § 1342(d)(1)(B)(iv). Nothing in ERISA expressly compels PBGC to pursue claims on the terminated plan's behalf.
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> * * * *
>
> [A]lthough PBGC might be sued for an alleged breach of a fiduciary duty owed to a plan participant, the relevant duties are limited by Title IV of ERISA, and it does not follow that PBGC may be sued for its decision not to pursue an action against a third party.
>
> PBGC's discretionary decision not to pursue claims against the Fiduciary Defendants and Towers Perrin comes within the *Heckler* presumption against judicial review, and nothing in ERISA rebuts the presumption. Accordingly, we hold that the PBGC's decision is immune from judicial review and affirm the dismissal of the Employees' sixteenth claim for relief.

Paulsen v. CNF Inc., *supra*, 559 F.3d at 1086–87.

The Paulsen case is instructive on the needless complications and delay, and the creation of unnecessary issues for appeal, that would occur if Plaintiffs were compelled to join PBGC. In Paulsen it led to a circuity of rulings that went on for over five years. This case is already sufficiently complex and time-consuming, without adding the

unnecessary complications that certainly would be created by joining PBGC, such as confronted the court in Paulsen.

All of these arguments against the Court requiring PBGC involvement in this case would apply with equal force if any of the Defendants should to bring PBGC into the case by motion. Any such motion should not be brought and should be denied if it were. However, the fact that PBGC is susceptible to suit here is another reason why the Court should not compel joinder of PBGC. See Thunder Basin Coal Co. v. Southwestern Public Service Co., supra, 104 F.3d at 1211 (10th Cir. 1997) ("Underlying the Seventh Circuit's decision is this proposition: if the defendant is capable of bringing into the litigation a nonparty whose presence is allegedly required to fully resolve the controversy and if that nonparty is otherwise capable of intervening, then the nonparty cannot be considered indispensable under Rule 19(b).") (citing with approval Pasco Int'l (London) Ltd. v. Stenograph Corp., *supra*, 637 F.2d at 503) (other citations omitted).

Defendants seek to explain the absence of church plan cases addressing PBGC's status as a necessary party by arguing that the case *sub judice* is unique, in that it involves a pension plan mislabeled as a church plan, administered by an employer that was financially unable to make the contributions required to fund the plan. See Prospect Entities' Memo. at 20 n.11 ("These circumstances—one in which the Plan is allegedly in dire financial conditions—appear to be relatively unique[[317]] in the context of 'church plan' lawsuits. This explains why other 'church plan' cases have not had to address the necessary role of the PBGC in the proceedings.").

[317] The phrase "relatively unique" is an oxymoron.

As discussed below, such cases are by no means unique. In any event, the reason why there are no church plan cases in which PBGC was claimed to be a necessary party is due to the fact that such cases do not meet the requirements for compulsory joinder under Rule 19, in that the absence of PBGC in such cases does not prevent complete relief between the parties, PBGC does not claim a legally protected interest in the subject matter of those cases, and PBGC's decision not to intervene is not subject to judicial review.

In fact, there have been church plan cases involving employers in financial difficulty before this. See, e.g., Thorkelson v. Publishing House of the Evangelical Lutheran Church in America, *supra*, 2012 WL 12905832 (D. Minn. 2012) (pension plan underfunded by $70,000,000, employer had reserves of only $84,000, PBGC not involved). The plan involved in Thorkelson especially would have been a candidate for PBGC involvement under Defendants' reasoning, since when the case was filed to adjudicate the plan's status as a church plan, the employer was unable to fund the plan and the plan had already been terminated and plan assets distributed, at great loss to plan participants. Thorkelson, 2012 WL 12905832, at *2 ("Plan participants lost the bulk of their vested retirement savings. Lump sum payments were made to plaintiff class members, but plaintiffs nonetheless sustained significant financial losses. Some retired in reliance on a pension only to discover that they will likely become dependent on government benefits."). If that plan had been covered by ERISA, as the plaintiffs alleged, the terminated plan would have been immediately subject to PBGC's guarantee. Nevertheless PBGC was not involved.

Indeed, the scenario of an employer experiencing financial distress leading to underfunding a defined benefit pension plan is not uncommon. See generally Stapleton v. Advocate Health Care Network, 817 F.3d 517, 526 (7th Cir. 2016) ("The *amici* briefs in support of the defendant-appellants are **replete with examples** of hospitals that, after receiving a letter ruling from the IRS finding that the hospital's pension plan qualified as a church plan, converted their plans into ones not governed by the protections of ERISA. **Then, when those hospitals encountered financial trouble**, their employees were left with severely underfunded and uninsured pension plans.") (emphasis supplied), rev'd on other grounds, Advocate Health Care Network v. Stapleton, 137 S.Ct. 1652 (2017).

E. Plaintiffs' Claims for Aiding and Abetting Breaches of Fiduciary Duty Are Proper under ERISA, and the Remedies That Plaintiffs Are Seeking Are Available under ERISA

1. Against the Prospect Entities

In Count III, Plaintiffs assert claims against the Prospect Entities for aiding and abetting breaches of fiduciary duties under ERISA. The Prospect Entities' argument as to why these claims must be dismissed is a mélange of statements concerning whether ERISA permits such claims and the remedies Plaintiffs' are seeking against the Prospect Entities.

It is difficult if not impossible to pin down the Prospect Entities' arguments, but one thing is absolutely clear, which is that the Prospect Entities, with the exception of their "strangers to the Plan" argument,[318] make no attack whatsoever on the factual

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[318] Discussed in Plaintiffs' Memo. in Oppo to the Prospect Entities' motion to dismiss, at 27-29.

sufficiency of the allegations in the Complaint to state a claim that they knowingly participated in, and aided and abetted, Defendant SJHSRI's breaches of fiduciary duties imposed by ERISA. Indeed, they do not even note, much less dispute, any of Plaintiffs factual allegations supporting this claim. Instead, their efforts to dismiss this claim are based on technical, legal arguments concerning whether ERISA allows claims for aiding and abetting breaches of fiduciary duty, and, if so, who may be sued and what remedies are available. As movants under Rule 12(b)(6), the Prospect Entities have the burden of proving their claims. Wright & Miller, et al., Federal Practice and Procedure: Civil 3d § 1357 ("All federal courts are in agreement that the burden is on the moving party to prove that no legally cognizable claim for relief exists."). These Defendants' tactical decision to focus their attack on technical legal arguments means that the factual sufficiency of Plaintiffs' claim is established for purposes of their motion to dismiss.

As noted, the Prospect Entities' arguments are not clear. However, it appears they may be contending that they cannot be sued for aiding and abetting SJHSRI's breach of fiduciary duty under 29 U.S.C. § 1132(a)(3), because they are neither an ERISA fiduciary nor an ERISA "party-in-interest." If that is their contention, they are mistaken.

Under 29 U.S.C. § 1132(a)(3), "[a] civil action may be brought... by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). In Harris Trust and Savings Bank v.

Salomon Smith Barney, Inc., 530 U.S. 238 (2000) the Supreme Court noted that the statute places no limits on who may be a defendant, stating:

> While § 502(a)(3) [29 U.S.C. § 1132(a)(3)] does not authorize "appropriate equitable relief" at large, but only for the purpose of "redress[ing any] violations or ... enforc [ing] any provisions' of ERISA or an ERISA plan [...], **the section admits of no limit (aside from the "appropriate equitable relief" caveat) on the universe of possible defendants**. Indeed, § 502(a)(3) [29 U.S.C. § 1132(a)(3)] makes no mention at all of which parties may be proper defendants-the focus, instead, is on redressing the "act or practice which violates any provision of [ERISA Title I]."

Harris Trust and Savings Bank v. Salomon Smith Barney, Inc., *supra*, 530 U.S. at 239 (emphasis supplied). See Cyr v. Reliance Standard Life Ins. Co., 642 F.3d 1202, 1206 (9th Cir.2011) (noting the Supreme Court in Harris Trust "rejected the suggestion that there was a limitation contained within [29 U.S.C. § 1132(a)(3)] itself on who could be a proper defendant in a lawsuit under that subsection").

That forecloses the Prospect Entities' argument that only ERISA fiduciaries and parties-in-interest can be sued under 29 U.S.C. § 1132(a)(3). Since Harris, numerous courts have held that 29 U.S.C. § 1132(a)(3) authorizes suits against defendants who are neither fiduciaries nor parties-in-interest for knowingly participating in an ERISA fiduciary's breach of duty. See Solis v. Couturier, No. 2:08CV02732-RRB-GGH, 2009 WL 1748724, at *4 (E.D. Cal. June 19, 2009) (allowing suit for knowing participation in breach of fiduciary duty) ("When the Supreme Court states that there is 'no limit . . . on the universe of possible defendants' who knowingly participate in a fiduciary's violation, this Court must conclude that 'no limit' means 'no limit'. Therefore, to the extent that Ninth Circuit case law previously limited the universe of § 502(a)(3) [29 U.S.C. § 1132(a)(3)] or § 502(a)(5) defendants to fiduciaries and parties in interest (the Court is

unconvinced that it did so), that case law has been superseded by *Harris Trust*.”); Chesemore v. Alliance Holdings, Inc., 770 F. Supp. 2d 950, 978 (W.D. Wis. 2011) (allowing suit against sellers of inflated stock to ERISA plan who thereby knowingly participated in fiduciary’s imprudent investments) (“Under § 502(a)(3), a participant may seek equitable relief from both fiduciaries and from non-fiduciaries who knowingly participate in an ERISA violation.”).

In Daniels v. Bursey, 313 F. Supp. 2d 790 (N.D. Ill. 2004) the court held that plaintiffs stated a knowing participation claim when non-fiduciary insurance companies actively participated in the fiduciary's mismanagement of plan investments, rejecting the arguments now asserted by the Prospect Entities:

> The Insurance Companies read *Harris* more narrowly, insisting that it applies only to claims brought against a nonfiduciary party in interest for violations of § 406 and that the Insurance Companies are not parties in interest. The Court disagrees with this narrow reading of *Harris*. In *Harris* the Supreme Court interpreted § 502(a)(3), not § 406, and accordingly it governs any suit under § 502(a)(3) alleging a violation of any substantive provision of ERISA.

Daniels, 313 F. Supp. 2d at 809. See also Chao v. Johnston, No. 1:06-CV-226, 2007 WL 2847548, at *6 (E.D. Tenn. July 9, 2007) (“[B]ased upon this precedent, liability does not depend upon whether the nonfiduciary can be classified as a party-in-interest nor whether the nonfiduciary participated in a prohibited transaction. Accordingly, the relevant issue the Court must determine is whether Plaintiffs sufficiently alleged Johnston ‘knowingly’ participated in another's fiduciary breach.”) (referring to Harris Trust).

The Prospect Entities seek to cabin Harris Trust by arguing that “the Supreme Court nonetheless made clear that the only type(s) of defendants capable of being

included were those from whom 'appropriate equitable relief' can be obtained.'"

Prospect Memo. at 29. We agree. However, the Supreme Court in Harris Trust also made clear that what constitutes "appropriate equitable relief" is determined by the law of trusts:

> Salomon raises the specter of § 502(a)(3) suits being brought against innocent parties—even those having no connection to the allegedly unlawful "act or practice"—rather than against the true wrongdoer, i.e., the fiduciary that caused the plan to engage in the transaction.
>
> But this *reductio ad absurdum* ignores the limiting principle explicit in § 502(a)(3): that the retrospective relief sought be "appropriate equitable relief." The common law of trusts, which offers a "starting point for analysis [of ERISA] ... [unless] it is inconsistent with the language of the statute, its structure, or its purposes," plainly countenances the sort of relief sought by petitioners against Salomon here.

Harris Trust, *supra*, 530 U.S. at 250-51 (quoting Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 447 (1999)). Thus, whether the Prospect Entities are proper defendants under ERISA depends upon whether they would be proper defendants under the common law of trusts. Carlson v. Principal Financial Group, 320 F.3d 301, 308 (2d Cir. 2003) ("Under *Harris Trust*, a non-fiduciary may be a proper defendant under § 502(a)(3) if it would be a proper defendant under 'the common law of trusts'".) (quoting Harris Trust, 530 U.S. at 250).

Plaintiffs' aiding and abetting claim against the Prospect Entities is proper because it is based on the common law of trusts:

> Just as every owner of a legal interest has the right that others shall not, without lawful excuse, interfere with his possession or enjoyment of the property or adversely affect its value, so the beneficiary, as equitable owner of the trust *res* has the right that third persons shall not knowingly join with the trustee in a breach of trust. One acting with a trustee in performing an act that such person knows or should know is a breach of

> trust becomes a participant in the breach and subject to liability for any damages that result or to restore the trust property traced to such person's possession.

Bogert's, The Law of Trusts and Trustees § 901 (June 2018 update) (citations omitted). See Pension Ben. Guar. Corp. v. Ross, 733 F. Supp. 1005 (M.D.N.C. 1990) (holding that plaintiffs had a "cognizable cause of action against…a non-fiduciary for its knowing participation in a breach of trust"); Pension Ben. Guar. Corp. v. Ross, *supra*, 733 F. Supp. at 1008 ("The law of trusts recognizes a cause of action against third persons for their knowing participation in a breach of trust. Seen in this light, defendants' argument must falter to the extent that trust law cannot be ignored in an ERISA case.") (citations omitted).

Because their position is untenable, the Prospect Entities fall back on the argument that, even if Plaintiffs might have a claim that the Prospect Entities acted wrongfully under the law of trusts, Plaintiffs cannot recover because they have no equitable remedy against the Prospect Entities, and are, in reality, seeking money damages. Prospect Memo. at 36 ("Even if Plaintiffs could find some cogent basis for bringing claims against the non-fiduciary Prospect Entities under ERISA § 502(a)(3), those claims ultimately would fail because Plaintiffs are seeking a patently non-equitable remedy: money damages."). In other words, even if the Prospect Entities are responsible for a breach of trust, they claim that Plaintiffs have no remedy.

That argument must be rejected as contrary to the "maxim of equity . . . that '[e]quity suffers not a right to be without a remedy.'" CIGNA Corp. v. Amara, 563 U.S. 421, 440 (2011) (quoting R. Francis, Maxims of Equity 29 (1st Am. ed. 1823)).

> Equity is primarily responsible for the protection of rights arising under trusts, and will provide the beneficiary with whatever remedy is necessary

> to protect him and recompense him for loss, in so far as this can be done without injustice to the trustee or third parties.
>
> The court is not confined to a limited list of remedies but rather will mold the relief to protect the rights of the beneficiary according to the situation involved. If equity cannot give the beneficiary the exact benefit to which the trust would entitle him, it will provide him the best possible substitute.

Bogert's, The Law of Trusts and Trustees § 861 (citations omitted).

However, this is not a case in which an existing equitable remedy is lacking such that the Court needs to fashion relief. To the contrary, there are equitable remedies which would entitle Plaintiffs to a monetary award against the Prospect Entities for aiding and abetting breach of fiduciary duty, notwithstanding that it is not alleged that the Prospect Entities obtained Plan assets.

First, the fact that "relief takes the form of a money payment does not remove it from the category of traditionally equitable relief" that may be awarded for a non-fiduciary's knowing participation in a fiduciary's breach of duty. CIGNA Corp. v. Amara, 563 U.S. 421, 441 (2011) ("But the fact that this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief. Equity courts possessed the power to provide relief in the form of **monetary 'compensation' for a loss resulting from a trustee's breach of duty**, or to prevent the trustee's unjust enrichment.") (emphasis supplied) (quoting Restatement (Third) of Trusts § 95, and Comment a (Tent. Draft No. 5, Mar. 2, 2009) and J. Eaton, Handbook of Equity Jurisprudence §§ 211–212, at 440 (1901)).

Second, that relief is not confined to recovering money wrongfully obtained from the Plan. Notably the Supreme Court in CIGNA Corp. v. Amara used the disjunctive "or" in referring to the two purposes of an equitable award of money compensation:

"compensation for a loss resulting from a trustee's breach of duty" *or* "to prevent the trustee's unjust enrichment." The Supreme Court identified and acknowledged that the equitable remedy that applies to an award of money compensation for a loss resulting from a trustee's breach of duty is the remedy of "surcharge", which "extend[s] to a breach of trust committed by a fiduciary encompassing **any violation of a duty imposed upon that fiduciary**." CIGNA Corp. v. Amara, supra, 563 U.S. at 442, 131 S.Ct. at 1880 (emphasis supplied) ("The surcharge remedy extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary."). See Chesemore v. Alliance Holdings, Inc., 948 F. Supp. 2d 928, 940 (W.D. Wis. 2013) (listing a wide range of equitable remedies available under 29 U.S.C. § 1132(a)(3)) ("This relief includes injunction, rescission, reformation, equitable estoppel and 'surcharge,' which is 'monetary compensation for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment.'") (quoting CIGNA Corp. v. Amara, 563 U.S. at 441-42). See also Paige v. Pellerin Milnor Corp., No. CV 16-17785, 2017 WL 1251203, at *5 (E.D. La. Apr. 5, 2017) (referring to "surcharge" as "the term of art for an equity court's award of monetary relief").

The equitable remedy of surcharge permits "an award of make-whole relief," CIGNA Corp. v. Amara, 563 U.S. at 442, even if there is no loss to the ERISA Plan. Amara v. CIGNA Corp., 925 F. Supp. 2d. 242, 257 (D. Conn. 2012) ("[T]he Supreme Court clearly contemplates that surcharge is available under § 502(a)(3) even absent a loss to the ERISA plan itself."). See Bogert's, The Law of Trusts and Trustees § 861 ("In some cases the object in assessing damages is to deter trustees from the commission of breaches of trust even though the trust itself has suffered no loss.").

Thus, the equitable remedy of surcharge enables a victim of a breach of trust involving an ERISA plan to be made whole for losses proximately caused by a breach of fiduciary duty even if those losses did not involve benefits under that plan. See In re DeRogatis, 904 F.3d 174, 199 (2d Cir 2018) (equitable remedy of surcharge may compensate beneficiary for losses from breach of duty by fiduciary to an ERISA *welfare plan* which caused beneficiary to receive less benefits from an ERISA *pension plan*) ("Emily asserts that, but for the Welfare Fund's fiduciary breach, Frank would have timely retired and applied for (and received) the 100% Joint Annuity. The 100% Joint Annuity is a benefit defined under the Pension Plan, however, not the Welfare Plan. Even if Emily successfully proved that the Welfare Fund breached a fiduciary duty, the District Court could not enjoin the Welfare Fund to enroll her in a survivor benefit over which that Fund has no control. Even so, DeRogatis might be entitled to an equitable surcharge remedy that would compensate her for the difference between the 100% Joint Annuity and the Preretirement Annuity, both retrospectively and on an ongoing basis."); Kenseth v. Dean Health Plan, Inc., 722 F.3d 869, 883 (7th Cir. 2013) (ERISA health plan participant entitled to remedy of surcharge to recover costs of medicals bills that fiduciary had mistakenly claimed would be covered) (Plaintiff "may seek an appropriate equitable remedy including make-whole relief in the form of money damages.").

As noted in Plaintiffs' memorandum in opposition to their motion to dismiss, the Prospect Entities do not dispute the factual allegations on which Plaintiffs' claim for aiding and abetting breach of fiduciary duties, with the exception of their "stranger to the plan" argument which Plaintiffs in turn dispute. Accordingly, because their merits-based

defense is based on disputed facts and Plaintiffs have disposed of the Prospect Entities' technical legal arguments, their motion to dismiss this claim must be denied.

It should be noted, however, that in responding to the Prospect Entities' motion to dismiss, Plaintiffs are not required, and it is premature, to determine exactly what equitable remedies Plaintiffs ultimately may have against the Prospect Entities. See Smoak v. Cangialosi, No. CV 2:17-1709-RMG, 2017 WL 4481159, at *3 (D.S.C. Oct. 6, 2017) (denying motion to dismiss plaintiff's claims against a non-fiduciary for knowing participation in a fiduciary's breach of fiduciary duty) ("Third, the ADP Defendants argue that payment of money is not a remedy available in equity. That argument is without merit. Although money damages are considered a legal remedy, not an equitable one, many equitable remedies may require a party to remit money to another party—e.g., *quantum meruit*, restitution and disgorgement, and constructive trust. Again, **whether Plaintiffs ultimately have a remedy in equity is not a question the Court will decide at the pleading stage.**") (emphasis supplied).

Such remedies may include a monetary award sufficient to fully fund the Plan as Defendant SJHSRI promised Plan participants, either in the form of a surcharge or as part of a claim for equitable estoppel. See Schmitt v. Nationwide Life Ins. Co., No. 2:17-CV-558, 2018 WL 4051835, at *3 (S.D. Ohio Aug. 24, 2018) (plaintiffs' knowing participation claim against nonfiduciary entitles them to monetary compensation including remedy of surcharge because no legal remedy is available under ERISA) ("Here, no such legal relief exists. Ms. Schmitt may therefore seek disgorgement, accounting, and **surcharge** remedies in equity.") (emphasis supplied); Enniss v. Enniss, 198 F. App'x 594, 596 (9th Cir. 2006) (where plaintiff proved equitable estoppel claim

that defendants reneged on promise to establish a pension, ERISA remedies include an injunction ordering defendant to fund a trust as promised) ("We reject Appellants' argument that the district court's remedy for Chip's promissory estoppel claim was outside the scope of ERISA § 502(a)(3) (29 U.S.C. § 1132(a)(3)), which authorizes plan beneficiaries to bring civil actions against fiduciaries 'to obtain other appropriate equitable relief.'"); Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945, 956 (9th Cir. 2014) ("'[A]ppropriate equitable relief' may include the remedy of equitable estoppel, which holds the fiduciary 'to what it had promised' and 'operates to place the person entitled to its benefit in the same position he would have been in had the representations been true.' ") (quoting CIGNA Corp. v. Amara, *supra*, 131 S.Ct. at 1880); De Pace v. Matsushita Elec. Corp. of America, 257 F. Supp. 2d 543, 565 (E.D.N.Y. 2003) (approving award of front pay to compensate plaintiffs who retired based upon representations concerning their ERISA plan which defendants were equitably estopped from denying).

2. Against Angell

In Count III Plaintiffs also assert claims against Angell for aiding and abetting breaches of fiduciary duties under ERISA. The grounds upon which Angell seeks dismissal of this claim include the legal arguments previously addressed concerning the Prospect Entities.

3. Against the Diocesan Defendants

In Count III Plaintiffs also assert claims against the Diocesan Defendants for aiding and abetting breaches of fiduciary duties under ERISA. The grounds upon which

they Diocesan Defendants seek dismissal of this claim include the legal arguments previously addressed concerning the Prospect Entities.

The Diocesan Defendants also a case in addition to the cases cited by the Prospect Entities addressed above. They cite Laurent v. Pricewaterhouse Coopers LP, 06-CV-2280 (JPO), 2017 WL 3142067 at *9 (S.D.N.Y. Jul. 24, 2017) as "holding that claim for surcharge was at bottom seeking monetary compensation for loss resulting from breach of duty and is barred as outside of the relief authorized by § 1132(a)(3))." Diocesan Defendants' Memo. at 81. That is a mischaracterization, since in that case the court merely held that the plaintiffs had not stated a claim for surcharge because the plaintiffs failed to show a breach of fiduciary duty:

> Plaintiffs attempt to restyle their requested relief as equitable—characterizing it as an accounting for profit, surcharge, unjust enrichment, or a constructive trust. (Dkt. No. 212 at 18-20.) But, at bottom, they are pursuing a legal claim for money damages. Of course, "[e]quity courts possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment." *Amara*, 563 U.S. at 441-42 (emphasis added) (quoting *Restatement (Third) of Trusts* § 95 & cmt. a (Tent. Draft No. 5, Mar. 2, 2009)). **But Plaintiffs fail to demonstrate the breach of any duty and have not shown any unjust enrichment.** As the Second Circuit did in *Nechis*, the Court here "decline[s] this invitation to perceive equitable clothing where the requested relief is nakedly contractual." *Nechis*, 421 F.3d at 104.

Laurent v. Pricewaterhouse Coopers LP, *supra*, 2017 WL 3142067, at *9 (emphasis supplied) (quoting Nechis v. Oxford Health Plans, Inc., 421 F.3d 96, 104 (2d Cir. 2005)).

Similarly, the court in Nechis held that Plaintiffs had not asserted valid claims for breach of fiduciary duty based on certain disclosure violations, because there were no disclosure violations, such that Plaintiffs' request for equitable remedies was not based upon an equitable claim. Nechis v. Oxford Health Plans, Inc., *supra*, 421 F.3d at 102-03

("As the district court concluded, Nechis's allegations with respect to disclosure violations and concerning reformation of claims resolution and appeals procedures are unavailing. Oxford has no duty to disclose to plan participants information additional to that required by ERISA; Oxford is not bound to inform participants either that it has adopted cost-containment mechanisms or that it offers financial incentives for cost savings."). In contrast, Plaintiffs' Complaint explains in great detail the breaches of fiduciary duty upon which Plaintiffs' claims of aiding and abetting are based, upon which Plaintiffs are entitled to equitable remedies, including surcharge.

The Diocesan Defendants make the argument that "[s]urcharge, moreover, is not available for the additional reason that Plaintiffs do not allege that the Diocesan Defendants were ERISA fiduciaries." Diocesan Defendants' Memo. at 81 n.50. That merely restates the Prospect Entities arguments that under ERISA, equitable relief is not available against non-fiduciaries, which Plaintiffs have fully addressed.

The Diocesan Defendants make one argument that the Prospect Entities do not, which is that "Plaintiffs Still Fail To State A Claim For ERISA Equitable Estoppel." Diocesan Defendants' Memo. at 81. They argue that "[a]ssuming equitable estoppel is available at all under § 1132(a)(3), the First Circuit has held that estoppel cannot modify an ERISA plan, but is only available where the representation at issue interprets an ambiguous plan provision." Diocesan Defendants' Memo. at 81-82 (citing Guerra-Delgado v. Popular, Inc., 774 F.3d 776, 782 (1st Cir. 2014) ("We have in the past assumed that any such claim under ERISA is necessarily limited to statements that interpret the plan and cannot extend to statements that would modify the plan.")).

This argument has no application in the circumstances of this case, in which the plan was not drafted with the intention of complying with ERISA and does not comply with ERISA. The quoted statement from Guerra-Delgado is addressed solely to equitable estoppel to deny statements that concern a plan drafted to comply with ERISA, because of a perceived conflict between allowing such claims and the law under ERISA is that "a plan cannot be modified orally." Guerra-Delgado v. Popular, Inc., *supra*, 774 F.3d at 783 (citing Law v. Ernst & Young, 956 F.2d 364, 370 n.9 (1st Cir. 1992)). Here the Plan was drafted as if ERISA did not apply, and, consequently, did not set forth SJHSRI's obligation to meet minimum funding standards and inform plan participants of the Plan's grossly underfunded status.

One of Plaintiffs' equitable estoppel claims could be that SJHSRI is estopped to deny its promises that it was funding the Plan and that it was required to fund the Plan. Both of those promises are required by ERISA. It is absurd for the Diocesan Defendants to argue that ERISA prohibits the Plan participants from employing equitable estoppel to vary the terms of a Plan that was not intended to (and did not) comply with ERISA.

F. Plaintiffs' State Law Claims Are Not Preempted

All Movant Defendants argue or join in arguments that all of Plaintiffs' state law claims should be dismissed as they are preempted by ERISA." In fact, none of Plaintiffs' state law claims can be dismissed on preemption grounds, because they are all plead in the alternative.[319]

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[319] Herein Plaintiffs consolidate their arguments concerning ERISA preemption that are not specific to any particular state law claim. In addition, Plaintiffs' fraudulent transfer claims against the Prospect Entities

1. Preemption Arguments Cannot Be Decided on a Motion to Dismiss When State Law Claims Are Pled in the Alternative

The Movant Defendants' arguments as to why all of Plaintiffs' state law claims should be dismissed have a common characteristic: they are predicated on the assumption that ERISA applies to Plaintiffs' claims. However, that has yet to be determined. Rule 8's allowance for alternative pleadings forecloses a motion to dismiss on grounds of preemption.

> In the ERISA context, in particular, there will often be good reason for alternatively pleading state and federal claims. When there is some doubt over whether ERISA is applicable under a given set of facts, especially where there is doubt about whether a particular plan is in fact an ERISA plan, proceeding in any other way can be hazardous for the plaintiff. If the plaintiff brings only state law claims and the court determines there is an ERISA plan, the state law claims are preempted. But if the plaintiff brings only an ERISA claim and the plan turns out not to be an ERISA plan, the plaintiff is also out of luck. Thus, ERISA preemption often presents the sort of situation for which Rule 8's alternative pleading provision is designed.

Coleman v. Standard Life Ins., Co., *supra*, 288 F. Supp. 2d at 1120.

Thus, the fact that ERISA, if applicable, might preempt state law claims does not preclude pleading those claims in the alternative, when the applicability of ERISA has not been established. See Siegel v. Lincoln Fin. Grp., No. CIV. 14-0289 KM SCM, 2015 WL 1307384, at *2 (D.N.J. Mar. 23, 2015) (denying motion to dismiss and allowing alternative pleading of state law and ERISA claims where there was a dispute over whether 401K plan was governed by ERISA) ("Should discovery establish that the 401(k) plan is an ERISA plan, the state law claims may not survive. If not, or if they lie

---

are not preempted by ERISA, for the reasons discussed in Plaintiffs' separate memorandum in support of their objection to the Prospect Entities' motion to dismiss.

outside the scope of preemption, then the state law claims may survive."); Duncanson v. Northwire, Inc., No. CV 10-2300 (PAM/JIB), 2010 WL 11565543, at *3 (D. Minn. Sept. 30, 2010) (refusing to dismiss on preemption grounds a count for equitable estoppel that "purports to arise under either ERISA or state law").

Accordingly, the Movant Defendants' contention that all of Plaintiffs' state law claims should be dismissed because they are preempted must be denied. The following arguments offer further reasons why these preemption arguments are unavailing.

2. It Is Not Established Whether ERISA Applies as a Result of the Plan Being Put into Receivership

The Prospect Entities argue that "Plaintiffs allege, and the Prospect Entities concede, that the Plan currently is subject to ERISA because the Receiver is firmly in control of it, and has been since September 2017." Prospect Memo. at 13-14. However, none of the Defendants have answered the complaint, and, therefore, none of the Defendants have admitted or denied any of Plaintiffs' allegations.

It would be irrelevant if all of the Defendants had admitted that the Plan currently is subject to ERISA, however, because parties cannot stipulate to whether a plan is governed by ERISA. Woerner v. Fram Grp. Operations, LLC, 658 F. App'x 90, 94 n.4 (3d Cir. 2016) ("The District Court should not have accepted this stipulation as true because the existence of a plan is not a purely factual question but a mixed question of law and fact. . . . Parties are free to stipulate to the 'surrounding circumstances' indicating the existence and terms of an insurance plan, *Shaver v. Siemens Corp.*, 670 F.3d 462, 475 (3d Cir. 2012) (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1373

(11th Cir. 1982) (en banc)), but they cannot stipulate to the ultimate legal conclusion that the plan is governed by ERISA.").

3. The Prospect Entities' Preemption Arguments Fail Even If It Were Established That ERISA Applies as a Result of the Plan Being Put into Receivership

The Movant Defendants' preemption arguments fail even assuming, *arguendo*, that ERISA applies as a result of the Plan being placed in receivership, because all of Plaintiffs' state law claims against them are based upon causes of action that arose prior to the Plan being put into Receivership. ERISA preemption only applies to claims that arose when the plan was covered by ERISA, as shown by a line of cases involving church plans that had made a statutory election to be covered by ERISA.

The conclusion of these cases is that if the state law claim arose *after* the election, it was subject to preemption, but if it arose *before* the election, it was not. See Robinson v. Metro. Life Ins. Co., No. 12-CV-01373-JAM-AC, 2013 WL 1281868, at *6 (E.D. Cal. Mar. 27, 2013) ("The plain text of 29 U.S.C. § 1003(b)(2) states that a church plan is exempt from ERISA until it makes a § 410(d) election. There is no reference to retroactive ERISA coverage, and no basis for inferring it. Disability claims arising before the election are therefore not governed by ERISA, and claims arising after the election are."); Welsh v. Ascension Health, No. 3:08CV348/MCR/EMT, 2009 WL 1444431, at *8 (N.D. Fla. May 21, 2009) ("[T]his court likewise concludes that preemption in this case began at the time of Ascension's 2008 election and not before. Therefore, at the time Welsh's claims under the LTD plan arose in 2003 Ascension's church plan was not governed by ERISA."); Geter v. St. Joseph Healthcare Sys., Inc., 575 F. Supp. 2d 1244, 1250 (D.N.M. 2008) ("Until January 12, 2004, CHI's long-term disability plan was a

‘church plan[ ] with respect to which no election had been made.’ Thus, under the statute's plain language, ERISA did not preempt’ [sic] state law until January 12, 2004.”) (quoting 29 U.S.C. § 1003(b)); Catholic Charities of Maine, Inc. v. City of Portland, 319 F. Supp. 2d 88, 89–90 (D. Me. 2004) (“[T]the plain language of ERISA suggests that preemption occurs upon the ‘making’ or filing of a section 410(d) election.”).

The logic from these cases applied to our facts is that, assuming, *arguendo*, that the Plan first became subject to ERISA when it was put into receivership, none of Plaintiffs’ state law claims are preempted, because they all arose prior.

III. CONCLUSION

Defendants’ motions to dismiss on grounds of standing, ripeness, failure to join indispensable parties, ERISA preemption, or based on their legal arguments concerning the availability under ERISA of claims for aiding and abetting breach of fiduciary duties and the remedies available under ERISA for such claims should be denied. Similarly, their motion to compel joinder of PBGC should be denied.

Defendants’ motions also should also be denied for the additional reasons set forth in Plaintiffs’ separate memoranda.

Respectfully submitted,
Plaintiffs,
By their Attorney,

/s/ Max Wistow

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Dated: February 4, 2019

CERTIFICATE OF SERVICE

I hereby certify that an exact copy of the within document was electronically filed on the 4th day of February, 2019 using the Electronic Case Filing system of the United States District Court and is available for viewing and downloading from the Electronic Case Filing system. The Electronic Case Filing system will automatically generate and send a Notice of Electronic Filing to the following Filing Users or registered users of record:

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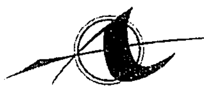
/s/ Max Wistow

Tab 1

Case Number PC-2017-3856
Filed in Pr vidence/B istol County Superi r Court
Submitted 8/18/2017 10:43:11 AM
Envel pe 1163836
Reviewer Janna F



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March 8, 2016

SENT VIA E-MAIL
PERSONAL & CONFIDENTIAL

Richard J. Land, Esq.
c/o Chace Ruttenberg & Freedman, LLP
One Park Row, Suite 300
Providence, RI 02903

RE: St. Joseph Health Services of Rhode Island Retirement Plan

Dear Richard:

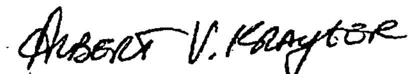
Enclosed is the following material pertaining to the annual administration of the above referenced Plan for the plan year beginning July 1, 2016 and ending June 30, 2017:

- The Actuarial Valuation, which outlines the funding options for the plan year and summarizes the current funding status of the Plan.

The valuation was prepared based on the Plan sponsor's conclusion and direction to the Angell Pension Group, Inc. that the Plan is a non-electing church plan within the meaning of Section 414(e) of the Internal Revenue Code of 1986, as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). As a non-electing church plan, the Plan is exempt from Titles I and IV of ERISA.

Please call me at extension 183 if you have any questions or need additional information. Simon Encarnacion is also available at extension 153.

Sincerely,



Albert V. Krayter
Director of Defined Benefit Department
akrayter@angellpensiongroup.com
admlet 2016.doc/A4360A/AVK

Enclosures

cc: Jeffrey A. Bauer, CPC, QPA, *The Angell Pension Group, Inc. (w/out enclosures)*

Case Number PC-2017-3856
Filed in Pr vidence/B istol County Superi r Court
Submitted 8/18/2017 10:43 AM
Envel pe: 1163836
Reviewer: Janna F

St. Joseph Health Services of Rhode Island Retirement Plan

Actuarial Valuation as of July 1, 2016

For the Plan Year Beginning July 1, 2016

and Ending June 30, 2017

Prepared By:

The Angell Pension Group, Inc.
88 Boyd Avenue
East Providence, RI 02914
401-438-9250

March 2017

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I. INTRODUCTION

This report presents the results of the actuarial valuation as of July 1, 2016 of the St. Joseph Health Services of Rhode Island Retirement Plan. The report is prepared for the plan year beginning July 1, 2016 and ending June 30, 2017. The purpose of the report is to:

- Illustrate the current actuarial position of the plan.
- Provide a summary of participant census and benefit detail.
- Present information which will assist the plan sponsor in determining the appropriate contribution for the plan year.
- Outline the actuarial assumptions and methods used.
- Summarize the results of our review of compliance with appropriate non-discrimination and/or top heavy requirements.

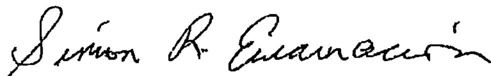
The asset smoothing method amortizes asset gains and losses over five years. Continued use of the "five-year" smoothing of gains and losses will spread gains and losses and prevent the plan from experiencing the full impact of recent market fluctuations. It is our understanding that there were no contributions deposited to the plan for the plan year ending June 30, 2016.

The valuation was prepared based on the Plan sponsor's conclusion and direction to the Angell Pension Group, Inc. that the Plan is a non-electing church plan within the meaning of Section 414(e) of the Internal Revenue Code of 1986, as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). As a non-electing church plan, the Plan is exempt from Titles I and IV of ERISA.

This valuation was prepared on the basis of information submitted to The Angell Pension Group, Inc. in the form of payroll and asset data, as well as ancillary material pertaining to the plan and the plan sponsor, and was prepared in accordance with current federal statutes and regulations, and consistent with current actuarial standards of practice. We have not independently verified, nor do we make any representations as to, the accuracy of such information.

The method for determining the actuarial value of plan assets includes a limitation so that the value is no less than 80% nor greater than 120% of the fair market value of plan assets. This limitation continues to allow smoothing but restricts its impact so that the actuarial value of assets remains reasonably close to the fair market value.

I meet the qualification Standard of the American Academy of Actuaries to render the actuarial opinions included in this report, based upon my education, experience and continuing education.



March 8, 2017

Simon R. Encarnacion, E.A., M.A.A.A.
Enrolled Actuary

Date

Albert V. Krayter
Director of Defined Benefit Department

II. VALUATION RESULTS

Contributions for Plan Year Ending June 30, 2017

Minimum Contribution:	$2,707,643
Recommended Contribution:	$4,599,689
Contribution to reach 100% funding level projected to the end of the plan year:	$43,032,480

Summary of Valuation Results:

Participants

	2016	2015
Active	471	508
Terminated vested	997	1,045
Retirees in pay status	1,229	1,178
Other (including per diem employees)	27	28
Total	2,724	2,759

Normal Cost

	2016	2015
Dollar amount	$ 0	$ 0
Covered payroll	N/A	N/A
As a percentage of payroll	N/A	N/A

Minimum Contribution

	2016	2015
Dollar amount	$ 2,707,643	$ 2,342,652
As a percentage of payroll	N/A	N/A

Assets

	2016	2015
Market Value	$ 86,780,384	$ 98,488,646
Actuarial Value	95,502,349	101,485,298
Net rate of return on market value	-1.81%	0.21%
Net rate of return on actuarial value (as limited by 80 – 120% limitations)	4.20%	8.04%

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Plan Assets as of July 1, 2016

Bank of America	$	86,780,384
Total Value of Plan Assets:	**$**	**86,780,384**

Actuarial Value of Plan Assets

Total Market Value of Plan Assets	$	86,780,384
Plus: Receivable Contributions		0
Plus: Adjustment to Actuarial Value		8,721,965
Less: Benefits Payable		0
Less: Advance Contributions		0
Less: Interest on Advance Contributions		N/A
Actuarial Value of Plan Assets	**$**	**95,502,349**

Actuarial Present Value of Accumulated Plan Benefits

The actuarial present value of accumulated plan benefits is a measurement of plan liabilities attributable to credited service and/or compensation as of a certain point in time. The information provided below can be used to satisfy Accounting Standard Codification Topic 960 ("ASC960", previously known as SFAS 35). It can also be used to gauge funding progress relative to plan assets.

The liability figures presented below are based upon actuarial assumptions which reflect the long term nature of an ongoing plan. The present values shown **do not** represent the liabilities that would be incurred to purchase annuity contracts or to pay single sums in the event of the termination of this Plan. The cost to purchase annuity contracts is dependent upon insurance company rates. The cost to pay single sums would necessitate a comparison with 30 year Treasury interest rates, or other IRS designated bond rates, and will generally be higher than the figures shown below.

The information in this section is based on the same actuarial assumptions as outlined in Section V of this report except that no salary scale assumption has been applied.

Present Values as of July 1, 2016

	Number of Lives	Vested Benefits	Non-Vested Benefits	Total Present Value
Active Lives:	471	$ 13,365,648	$ 192,400	$13,558,048
Vested Terminations/Inactives:	997	18,901,884	0	18,901,884
Disabled Lives:	0	0	0	0
Retired Lives:	1,229	93,637,424	0	93,637,424
Other (incl. per diem employees):	27	620,364	0	620,364
Totals:	**2,724**	**$ 126,525,320**	**$ 192,400**	**$126,717,720**

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Statement of Change in Accumulated Plan Benefits

Actuarial present value of accumulated plan benefits as of the prior valuation date		**$ 128,492,828**
Increase (decrease) during the year attributable to:		
Plan amendment	$	0
Change in actuarial assumptions		(1,379,392)
Benefits accumulated		88,215
Increase for interest due to the decrease in the discount period		9,537,503
Benefits paid		(10,021,434)
Net increase (decrease):	$	(1,775,108)
Actuarial present value of accumulated plan benefits as of the current valuation date		**$ 126,717,720**

III. SUMMARY OF PLAN PROVISIONS

Plan Effective Date:	July 1, 1965
Plan Description:	The Plan is a non-electing Church Plan within the meaning of Section 414e of the Code and Section 3(33) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended.
Eligibility Requirements:	Age: None Service: One Year Exclusions: Any Employees hired after October 1, 2007 will not be able to participate in this Plan, other than UNAP employees hired on or before October 1, 2008. Benefit Accruals for Non-Union participants were frozen on September 30, 2009. Benefit Accruals for Federation of Nurses and Health Professionals ("FNHP") participants were frozen on September 30, 2011. Benefit Accruals for Union participants were frozen on June 19, 2014
Year of Service:	12-consecutive-month computation period commencing on the employee's date of hire in which an employee is credited with 1,000 or more hours of service.
Year of Service for Benefit Accrual:	Service shall equal total plan years of service with the Employer. Prior to July 1, 2001, a year of service was credited for each plan year in which an employee was an active participant in the plan and was paid for at least 1,000 hours. On July 1, 2001 the plan was amended to use elapsed time to determine service through July 1, 2001. Thereafter, the 1,000 hour rule will continue to be used. Benefit Accruals for Non-Union participants were frozen on September 30, 2009. Benefit Accruals for Federation of Nurses and Health Professionals ("FNHP") participants were frozen on September 30, 2011. Benefit Accruals for Union participants were frozen on June 19, 2014
Plan Entry Date:	An eligible employee will enter the plan on the first of the month following completion of the eligibility requirements.
Normal Form of Benefit:	Life annuity

III. SUMMARY OF PLAN PROVISIONS (CONT'D)

Normal Retirement Date: The first day of the month coincident with or next following the later of age 65 or the fifth anniversary of the participant's participation.

Compensation: "Annual Earnings" means the basic rate of compensation, excluding bonus payments, call time, overtime and any irregular payments. In no event shall compensation for any year exceed the IRC limit on annual compensation includable in a defined benefit plan ($260,000 for 2014).

Average Compensation: The average of the five highest consecutive Annual Earnings during the ten years immediately preceding employee's termination of employment.

Normal Retirement Benefit: The amount of annual normal retirement benefit to be paid in monthly installments for life, based on credited service to normal retirement date, is:

1. Fifty percent of Final Average Earnings, less
2. Fifty percent of the Social Security Benefit

The above difference shall be multiplied by the ratio of the participant's credited service not in excess of 30 years over 30 years.

The annual retirement benefit can not be less than $48.00 multiplied by years of credited service, to a maximum of 30 years.

If an employee was a member on June 30, 1977, his benefit should not be less than the sum of (a) and (b) below:

(a) Future Service Benefit: 0.75% of Annual Earnings up to $4,800 plus 1.5% of Annual Earnings in excess of $4,800, for each year of future service.

(b) Past Service Benefit: 0.75% of Annual Earnings for each year of past service

Benefit Accruals for Non-Union participants were frozen on September 30, 2009.

Benefit Accruals for Federation of Nurses and Health Professionals ("FNHP") participants were frozen on September 30, 2011.

III. SUMMARY OF PLAN PROVISIONS (CONT'D)

Benefit Accruals for Union participants were frozen on June 19, 2014.

Accrued Benefit: The accrued benefit at any time prior to a participant's normal retirement date shall be the projected normal retirement benefit based on credited service projected to normal retirement and Final Average Earnings as of the accrual date multiplied by a fraction.

The numerator of this fraction is the number of years credited service on the accrual date and the denominator is the projected number of years of credited service at the later of age 60 or 30 years of service, but no later than normal retirement date. This fraction cannot exceed one. The plan was amended as of July 1, 2001 to change age 65 to age 60, for this purpose.

Benefit Accruals for Non-Union participants were frozen on September 30, 2009.

Benefit Accruals for Federation of Nurses and Health Professionals ("FNHP") participants were frozen on September 30, 2011.

Benefit Accruals for Union participants were frozen on June 19, 2014.

Early Retirement Benefit: Upon the completion of five years of continuous service and the attainment of age fifty-five, a participant may elect to retire. He may receive a monthly benefit for life beginning at his early retirement date equal to the benefit accrued at normal retirement date reduced by the following:

- First 60 months between early and normal retirement dates: 5/9% each month.
- Additional months after first 60 months prior to normal retirement date: 5/18% each month.
- If the participant has accumulated eighty-five points, (as of September 30, 2009 for Non-Union Participants) computed as the sum of age and continuous service at termination (years and complete months), and has attained the age of fifty-five he may receive an unreduced monthly benefit for life beginning at this early retirement date equal to his benefit accrued at termination.

III. SUMMARY OF PLAN PROVISIONS (CONT'D)

Late Retirement Benefit: A participant may continue in the employment of the Employer after his normal retirement date. In such event he will receive at actual retirement his accrued benefit calculated using service as of his actual retirement date.

Death Benefit: In the event of the death of an active married participant who completed five years of service whose benefit payments have not commenced, it will be assumed that the participant had separated from service on the date of death, survived to the earliest retirement age, began receiving a joint and one-half survivor benefit based on the participant's vested accrued benefit, and died on the day after the earliest retirement date.

A spouse may elect a life annuity, a lump sum, or a reduced benefit payable anytime from when the participant would have reached age fifty-five.

Vesting: Based on Years of Vesting Service, subject to the following schedule

Years of Service	Vested Percentage
Less than 5 years	0%
5 Years or more	100%

Notwithstanding the above vesting schedule, a participant will become 100% vested upon reaching Normal Retirement Date.

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IV. ACTUARIAL METHODS

Actuarial Cost Method

The ultimate cost of a pension plan cannot be determined until the last participant is paid and all obligations are discharged. An Actuarial Cost Method, rather than determining the cost of a pension plan, assigns the overall cost to a period of time. The Employee Retirement Income Security Act of 1974 (ERISA) specifies several acceptable cost methods. IRS regulations allow some variations among these methods.

Costs have been computed in accordance with the Accrued Benefit (Unit Credit) method, as described below.

The Normal Cost is the sum of individual normal costs for each participant who has not reached the assumed retirement age. The normal cost for a participant is determined as the actuarial present value of the projected benefit allocated to the current plan year.

In addition, there is a second cost component in which the payment, in the first plan year, is determined as an amortization of the unfunded accrued liability. The accrued liability is defined as the actuarial present value of the portion of the projected benefit that is allocated to prior plan years. This calculation is done for each participant, and then summed to get a total accrued liability. The unfunded accrued liability is the difference between the total accrued liability and the actuarial value of plan assets.

Under the Accrued Benefit (Unit Credit) Method, any change in the accrued liability resulting from experience gains or losses is calculated each plan year and separately amortized in accordance with minimum funding rules. In addition, changes in plan provisions or actuarial assumptions that result in an increase or decrease in the accrued liability will be separately amortized.

The method is the same method described in Section 3.01 of Internal Revenue Procedure 2000-40.

Asset Valuation Method

The actuarial value of the plan assets used in determining plan costs is equal to the "five-year" smoothing of gains and losses method. Under this method, asset gains and losses are recognized at the rate of 20% per year. As a result, the impact of appreciation or depreciation on valuation assets is smoothed. The resulting value is limited to be no less than 80% nor greater than 120% of the fair market value of plan assets. Even when the limitation applies the underlying "five-year" smoothing method will be maintained.

Changes In Actuarial Methods

No changes in actuarial methods have occurred since the prior plan year.

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V. ACTUARIAL ASSUMPTIONS

Assumptions Used For The Current Plan Year

Actuarial assumptions are estimates as to the occurrence of future events affecting the costs of the plan such as mortality rates, withdrawal rates, changes in compensation level, retirement ages, rates of investment earnings, expenses, etc. The assumptions have been chosen to anticipate the long-term experience of the plan. The enrolled actuary will certify to the reasonableness of these assumptions, as required by ERISA.

Pre-Retirement Investment Return: 7.75% per annum

Post-Retirement Investment Return: 7.75% per annum

Pre-Retirement Mortality: RP-2014 Employee (M/F) with Scale MP-2016 Generational Improvements from 2006

Post-Retirement Mortality: RP-2014 Healthy Annuitant (M/F) with Scale MP-2016 Generational Improvements from 2006

Withdrawal Rate: Select and ultimate rates of withdrawal are as follows:

	Mortality		Termination	
Age	Male	Female	Male	Female
25	0.000366	0.000207	0.066	0.099
30	0.000444	0.000264	0.050	0.077
35	0.000773	0.000475	0.034	0.054
40	0.001079	0.000706	0.018	0.032
45	0.001508	0.001124	0.012	0.021
50	0.002138	0.001676	0.006	0.011
55	0.003624	0.002717	0.000	0.000

In addition to the above rates, the following rates based on service are added to the termination rates for participants with 10 or fewer years of service:

Termination Service	Rate	Termination Service	Rate
1	10%	8	3%
2	9%	9	2%
3	8%	10	1%
4	7%		
5	6%		
6	5%		
7	4%		

V. ACTUARIAL ASSUMPTIONS (CONT'D)

Disability Rate: None

Salary Scale: None

Taxable Wage Base: None

Consumer Price Index: None

Expenses: None

Assumed Retirement Age: Beginning at age fifty-five, the following rates are assumed:

Age	Probability of Retirement
55	2.0%
56-59	0.8%
60-61	3.0%
62	15.0%
63	7.5%
64	10.0%
65	75.0%
66	80.0%
67	91.0%
68	100.0%

Marital Status: 100% of participants are assumed to be married; wives are assumed to be three years younger than their husbands.

Recommended Funding Level: The recommended contribution is based on the Plan's Normal Cost plus an amortization of the Plan's unfunded liability. If the plan is projected to have no unfunded liability at the end of the Plan Year then no contribution is recommended, if the asset surplus is greater than the Normal Cost. While the Plan is a church plan, and is not subject to the funding requirements of ERISA, the current funding policy follows the ERISA guidelines without regard to the current liability calculations or Pension Protection Act of 2006 modifications.

SECTION V (Cont.)

SELECTION OF ACTUARIAL ASSUMPTIONS

Assumption		Entity Who Selects Assumption	Basis for Assumption Selection	Change In Assumption
Discount Rate for Minimum Contribution	7.75%	The Angell Pension Group, Inc.	The interest rate is developed based on the allocation of the Plan's assets by investment class and the capital market outlook for each investment class. This information is provided by the Plan's investment advisor.	None
Inflation Rate	N/A	N/A	Long-term CPI-U experience.	None
Salary Scale	N/A	N/A	Plan benefits are frozen and do not depend on future salary.	None
Taxable Wage Base Increase	N/A	N/A	Plan benefits are frozen and do not depend on future taxable wage base.	None
IRC 415 and 401(a)(17) Limit Projection	N/A	N/A	Projected increases to benefit and pay limits are not applicable under the Actuarial Funding Method used for the Present Value of Accumulated Plan Benefits.	None
Pre-Retirement Mortality	RP-2014 Employee with Scale MP-2016 generational improvements from 2006 (M/F)	The Angell Pension Group, Inc.	The Society of Actuaries published a study of retirement experience in October, 2016. The RP-2014 tables presented in the study represent the most current and complete benchmarks of U.S. private pension plan mortality experience. These tables include projections of mortality improvement through 2016. The RP-2014 Mortality Table has been modified by removing the MP-2014 projections for years 2007 forward to arrive at a hypothetical "RP-2006" base table. Then this base table is projected from 2006 forward with MP-2016 Generational Projection (M/F)	The mortality tables changed from the RP-2014 Employee with Scale MP-2015 generational improvements from 2006 (M/F) as of the prior measurement date, July 1, 2015, to reflect the current prescribed tables. This change, together with the change in post-retirement mortality, decreased the Present Value of Accumulated Plan Benefits as of the current measurement date, July 1, 2016, by 1.08%.
Post-Retirement Mortality	RP-2014 Healthy Annuitant with Scale MP-2016 generational improvements from 2006 (M/F)	The Angell Pension Group, Inc.	The Society of Actuaries published a study of retirement experience in October, 2016. The RP-2014 tables presented in the study represent the most current and complete benchmarks of U.S. private pension plan mortality experience. These tables include projections of mortality improvement through 2016. The RP-2014 Mortality Table has been modified by removing the MP-2014 projections for years 2007 forward to arrive at a hypothetical "RP-2006" base table. Then this base table is projected from 2006 forward with MP-2016 Generational Projection (M/F)	The mortality tables changed from the RP-2014 Healthy Annuitant with Scale MP-2015 generational improvements from 2006 (M/F) as of the prior measurement date, July 1, 2015, to reflect the current prescribed tables. This change, together with the change in pre-retirement mortality, decreased the Present Value of Accumulated Plan Benefits as of the current measurement date, July 1, 2016, by 1.08%.
Disability Mortality	None	The Angell Pension Group, Inc.	The incidence of disability under the Plan is negligible.	None
Disability Rates	None	The Angell Pension Group, Inc.	The incidence of disability under the Plan is negligible.	None
Withdrawal Rates	Select and ultimate rates	The Angell Pension Group, Inc.	using rate applicable to plan experience	None
Retirement Rates	Employees were assumed to retire in accordance with rates shown below: Age Rates Age Rates 55 2.00 63 7.50 56 0.80 64 10.00 57 0.80 65 75 00 58 0.80 66 80.00 59 0.80 67 91.00 60 3.00 68 100.00 61 3.00 62 15.00	The Angell Pension Group, Inc.	This assumption was set based on a review of experience under the Plan.	None
Percent Married	100% of males and 100% of females are assumed to be married.	The Angell Pension Group, Inc.	This assumption was set based on a review of experience under the Plan.	None
Age of Spouse	The female spouse is assumed to be three years younger than the male spouse.	The Angell Pension Group, Inc.	This assumption was set based on a review of experience under the Plan and general experience from similarly situated plans.	None

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APPENDIX A Development of Normal Cost

The Normal Cost is the portion of plan benefit costs which is allocated to the current plan year by the Actuarial Cost Method being used. The following represents the development of the Normal Cost under the chosen Actuarial Cost Method, unless the method determines the normal cost on an individual participant basis.

1.	Present Value of Benefits	$	N/A
2.	Actuarial Value of Assets		N/A
3.	Unamortized Balance of Amortization Bases (412)/ Unfunded Liability (404)		N/A
4.	Funding Standard Account Credit Balance (412)/ Prior year's carry forward (404)		N/A
5.	Accumulated Reconciliation Account (412)		N/A
6.	Present Value of Future Normal Cost [(1) - (2) - (3) + (4) + (5)]		N/A
7.	Present Value of Future Compensation		N/A
8.	Current Compensation		N/A
9.	Normal Cost [(6) / (7) x (8)]		0
10.	Expense Load / Term Cost		0
11.	**Total Normal Cost [(9) + (10)]**	**$**	**0**

APPENDIX B Development of Contributions

1. Minimum Contribution	**July 1, 2016**	**July 1, 2015**
a. Actuarial funding level		
i. Accrued liability	126,717,720	128,492,828
ii. Actuarial Value of Assets	95,502,349	101,485,298
iii. Unfunded Actuarial Accrued Liability (UAAL) ((1.a.i. - 1.a.ii.), max 0)	31,215,371	27,007,530
b. 30 Year Amortization of UAAL	2,512,894	2,174,155
c. Normal cost	0	0
d. Interest (0.0775 x (1.b. + 1.c.))	194,749	168,497
e. Minimum Contribution [(1.b. + 1.c. + 1.d.), if 1.b. > 0)]	2,707,643	2,342,652
2. Recommended Contribution		
a. Normal Cost	0	0
b. 10 Year Amortization of UAAL	4,268,853	3,693,411
c. Interest (0.0775 x (2.a. + 2.b.))	330,836	286,239
d. Subtotal	4,599,689	3,979,650
e. Recommended Contribution (greater of (2d) and (1e), not less than 0)	4,599,689	3,979,650

3. Contribution to reach 100% funding level projected to the end of the plan year

		July 1, 2016	July 1, 2015
a.	Actuarial Funding Level		
	i. Lesser of Market Value and Actuarial Value of Assets	$ 86,780,384	$ 98,488,646
	ii. Projected beginning of year funding shortfall (1.a.i. + 1.c. - 3.a.i.)	39,937,336	30,004,182
	iii. Projected end of year funding shortfall (3.a.ii.x 1.0775)	43,032,480	32,329,506
b.	Contribution to reach 100% funding level projected to the end of the plan year	43,032,480	32,329,506

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APPENDIX C Development of Actuarial Value of Assets

Development of Actuarial Value of Assets

1.	Actuarial value as of July 1, 2015 (Without 80 - 120% limitations)	$ 101,485,298
2.	Market value as of July 1, 2015	98,488,646
3.	Employer contribution made during the Plan Year	0
4.	Benefit payments from July 1, 2015 through June 30, 2016	10,021,434
5.	Expected interest at 7.75% through June 30, 2016	
	a. On (1)	7,865,111
	b. On (3)	0
	c. On 13/24 of (4)	420,691
	d. Net expected interest [(a) + (b) - (c)]	7,444,420
6.	Expected market value as of June 30, 2016 [(2) + (3) - (4) + (5d)]	95,911,632
7.	Actual market value as of June 30, 2016	86,780,384
8	Market value gain (loss) from July 1, 2015 to June 30, 2016 [(7) - (6)]	(9,131,248)
9.	Recognition of actuarial value gain (loss) amounts	

	Plan Year Ending	Original Gain (Loss)	June 30, 2016 Balance	Amount to Recognize on July 1, 2016
a.	June 30, 2012	(9,476,777)	(1,895,357)	(1,895,355)
b.	June 30, 2013	2,868,182	1,147,274	573,636
c.	June 30, 2014	6,083,522	3,650,114	1,216,704
d.	June 30, 2015	(7,373,352)	(5,898,682)	(1,474,670)
e.	June 30, 2016	$(9,131,248)	(9,131,248)	(1,826,250)
f.			**Total:**	**$ (3,405,935)**

10.	Actuarial value as of July 1, 2016 [(1) + (3) - (4) + (5d) + (9f)]:	$95,502,349
11.	Actuarial value as a percentage of market value	110.05%
12.	Employer Contribution Receivable	$ 0
13.	Actuarial value as of July 1, 2016 including Employer Contribution Receivable	$95,502,349
14.	Actuarial value as of July 1, 2016 including Employer Contribution Receivable, limited to at least 80% and maximum of 120% of market value as of July 1, 2016	$95,502,349

APPENDIX D - Participant Data

A. Reconciliation of Participant Data

	Actives	Inactives Per-diem	Terminated with Vested Benefits	Retirees & Beneficiaries	Total
Total as of July 1, 2015	**508**	**28**	**1,045**	**1,178**	**2,759**
New Entrants	0	0	0	0	0
Rehires	0	0	0	0	0
Terminated Vested	(2)	0	2	0	0
Terminated Nonvested	0	0	0	0	0
New Retirees	(34)	(1)	(46)	81	0
New Beneficiaries	0	0	(1)	5	4
Active Deaths	0	0	0	0	0
Terminated Vested Deaths	0	0	(2)	0	(2)
Retiree/Beneficiary Deaths	0	0	0	(37)	(37)
Inactive Per-diem	0	0	0	0	0
Per-diem returned to Actives	0	0	0	0	0
Lump Sum Payment	(1)	0	(2)	(1)	(4)
Data Adjustments	0	0	1	3	4
Total as of July 1, 2016	**471**	**27**	**997**	**1,229**	**2,724**

Notes:

As of June 19, 2014 benefit accruals for Union Participants were frozen. No members under the Plan accrue any benefits as of July 1, 2014.

APPENDIX D - Participant Data (Continued)

B. Age and Service Distribution of Active Participants

Age	0-4	5-9	10-14	15-19	20-24	*Service* 25-29	30-34	35-39	40 +	Total
0-19	-	-	-	-	-	-	-	-	-	-
20-24	-	-	-	-	-	-	-	-	-	-
25-29	-	2	1	-	-	-	-	-	-	3
30-34	-	6	9	3	-	-	-	-	-	18
35-39	-	3	18	7	-	-	-	-	-	28
40-44	-	10	21	9	6	1	-	-	-	47
45-49	-	6	30	16	10	11	2	-	-	75
50-54	-	9	27	17	12	33	8	8	-	114
55-59	-	5	35	13	12	8	16	18	5	112
60-64	-	8	9	11	7	11	8	2	6	62
65-69	-	0	6	3	-	-	-	-	1	10
70-74	-	-	2	-	-	-	-	-	-	2
75-79	-	-	-	-	-	-	-	-	-	-
80-84	-	-	-	-	-	-	-	-	-	-
85+	-	-	-	-	-	-	-	-	-	-
Total	-	**49**	**158**	**79**	**47**	**64**	**34**	**28**	**12**	**471**

Tab 2

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St. Joseph Health Services of Rhode Island Retirement Plan

The following analysis has been prepared to present the current health of the St. Joseph Health Services of Rhode Island Retirement Plan (the "Retirement Plan"). The following exhibits are enclosed, each with specific assumptions and notes.

Exhibit A	Projected Insolvency of Retirement Plan
Exhibit B	Estimated Funded Liability -Annuity Basis (2.85%)
Exhibit C	Estimated Funded Liability - Lump Sum Basis (4.19%)
Exhibit D	Estimated Funded Liability - Ongoing Funding Basis (6.50%)
Exhibit E	Projection of Minimum Funding Requirements Under ERISA

The results contained in this analysis are for illustrative purposes only and are estimates based on the July 1, 2016 valuation census, updated for retirements and deaths known to date. All data, assumptions, methods, and plan provisions not specified in this report are the same as shown in the July 1, 2016 actuarial valuation report.

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May 8, 2017

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St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT A: Projected Insolvency of Retirement Plan

Duration	Year	Participant Count	Estimated Benefit Payment Stream	Estimated Plan Actuarial Expenses	Market Value of Assets Beg. of Year	Contributions During Year	Investment Earnings During Year	Expected Unfunded Benefit Payments
1	2017	2,710	$10,203,963	$110,000	$84,291,881	$0	$5,147,343	$0
2	2018	2,677	10,276,905	110,000	79,125,261	0	4,809,143	0
3	2019	2,642	10,455,150	110,000	73,547,499	0	4,440,795	0
4	2020	2,606	10,616,000	110,000	67,423,144	0	4,037,484	0
5	2021	2,568	10,726,446	110,000	60,734,628	0	3,599,141	0
6	2022	2,526	10,785,565	110,000	53,497,323	0	3,126,795	0
7	2023	2,482	10,897,830	110,000	45,728,553	0	2,618,176	0
8	2024	2,433	10,903,301	110,000	37,338,899	0	2,072,671	0
9	2025	2,387	11,010,593	110,000	28,398,269	0	1,488,043	0
10	2026	2,340	10,936,418	110,000	18,765,719	0	864,338	0
11	2027	2,291	10,911,883	110,000	8,583,639	0	203,300	2,234,944
12	2028	2,242	10,833,811	110,000	0	0	0	10,943,811
13	2029	2,191	10,675,548	110,000	0	0	0	10,785,548
14	2030	2,137	10,487,428	110,000	0	0	0	10,597,428
15	2031	2,083	10,307,785	110,000	0	0	0	10,417,785
16	2032	2,027	10,104,398	100,000	0	0	0	10,204,398
17	2033	1,969	9,874,653	100,000	0	0	0	9,974,653
18	2034	1,910	9,557,596	100,000	0	0	0	9,657,596
19	2035	1,849	9,244,059	110,000	0	0	0	9,354,059
20	2036	1,787	8,896,778	100,000	0	0	0	8,996,778
21	2037	1,724	8,512,506	100,000	0	0	0	8,612,506
22	2038	1,659	8,115,944	100,000	0	0	0	8,215,944
23	2039	1,593	7,723,476	100,000	0	0	0	7,823,476
24	2040	1,527	7,301,678	100,000	0	0	0	7,401,678
25	2041	1,460	6,874,430	100,000	0	0	0	6,974,430
26	2042	1,392	6,454,001	100,000	0	0	0	6,554,001
27	2043	1,324	6,026,184	100,000	0	0	0	6,126,184
28	2044	1,257	5,601,540	100,000	0	0	0	5,701,540
29	2045	1,190	5,196,267	100,000	0	0	0	5,296,267
30	2046	1,124	4,793,351	100,000	0	0	0	4,893,351
31-40	2047-2056		29,306,558	1,000,000	0	0	0	30,306,558
41-50	2057-2066		8,725,092	777,140	0	0	0	9,502,232
51-60	2067-2076		1,920,232	192,023	0	0	0	2,112,255
61-70	2077-2086		297,994	29,799	0	0	0	327,793
71-80	2087-2096		24,125	2,413	0	0	0	26,538
81-90	2097-2106		1,564	156	0	0	0	1,720
91-100	2107-2116		33	3	0	0	0	36

Projected Year of Insolvency with Investments Earning 6.50%:	**2027**
Projected Year of Insolvency with Investments Earning 7.75%:	**2028**
Projected Year of Insolvency with Investments Earning 4.50% (2% loss per year):	**2026**
Minimum Rate of Return on Investments to Avoid Insolvency:	**12.65%**
Duration of Payments (Years) at 6.50%:	**10.4**

St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT A: Projected Insolvency of Retirement Plan

Summary of Estimated Benefit Payments

Sum of all years:	$314,581,085	
Sum of first 10 years:	$106,812,171	34.0%
Sum of first 20 years:	$207,706,110	66.0%
Sum of first 30 years:	$274,305,487	87.2%
Sum of first 40 years:	$303,612,045	96.5%
Sum of first 50 years:	$312,337,137	99.3%

Assumptions and Notes:

- The primary purpose of this report is to present how long the plan assets may be expected to provide for the payment of the expected benefit payments and actuarial fees from the plan given the current level of plan assets, any expected contributions and estimated net investment earnings.

- The analysis is based on the July 1, 2016 valuation census, updated for retirements and deaths known to date. All data, assumptions, methods, and plan provisions are shown in the July 1, 2016 valuation report.

- Assets are based on **March 31, 2017 market value**. Future projections on Plan assets also assume a **6.50% rate of return**. The actual return on investments from year-to-year will impact the results of this projection.

- Expected benefit payments and contributions are expected to be made mid-year.

- Projected actuarial expenses are assumed to be $100,000 fixed fees plus a variable fee for expected benefit calculations (but in no event greater than 10% of expected benefit payments for a year).

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St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT B: Estimated Funded Liability -Annuity Basis (2.85%)

Projected Liability to Settle Benefit Obligations as of July 1, 2017

Allocation Group	Group Description	Participant Count	Estimated Benefit Liability	Estimated Benefits Covered by Plan Assets	Estimated Benefits NOT Covered by Plan Assets
1	Return of Employee Contributions	0	0	0	0
2	Retirees and Active/Vested Terms who reached their Normal Retirement Date	1,382	142,210,991	84,291,881	57,919,110
3	Active/Vested Terms who reached their Early Retirement Date	639	46,920,909	0	46,920,909
4	Active/Vested Terms prior to Early Retirement Date	703	21,344,417	0	21,344,417
	Totals:	**2,724**	**210,476,318**	**84,291,881**	**126,184,437**

Funding Percentage - Total Plan - Annuity Basis (2.85%):	***40%***
Flat Percent Decrease to All Benefits to Fully Fund:	***60%***

Immediate Plan Termination Funding Percentage	
- Allocation Group 2:	***59%***
- Allocation Groups 3 and 4:	***0%***

Assumptions and Notes:

- Estimated benefit liabilities are determined assuming annuities will be purchased from an insurance carrier as of July 1, 2017. Data is based on preliminary July 1, 2016 valuation census projected to July 1, 2017. Liabilities are valued using an effective discount rate of approximately **2.85%** and the RP-2014 mortality tables with generational improvement scale MP-2016 for males and females. The cost to purchase annuities has not been provided by an insurance carrier but is based on a current estimate of the discount rates. The rates are estimated based on the general movement of discount rates over the past 12 months. The actual assumptions used to determine the cost of annuities will depend on the insurance carrier selected by the Plan Sponsor and the economic environment at the time of the purchase of annuities, and the actual discount rates could be significantly different than the estimated discount rates. The actual liability must be determined by the insurance carrier selected by the Plan Sponsor.

- Assets are based on **March 31, 2017 market value, projected to July 1, 2017 based on 6.50% return.**

- Allocation groups are determined by Section 10.2 of the Plan document executed on January 30, 2017. Outside legal counsel should review the priority of the allocation groups since The Angell Pension Group, Inc. cannot render legal advice.

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St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT C: Estimated Funded Liability - Lump Sum Basis (4.19%)

Projected Liability to Settle Benefit Obligations as of July 1, 2017

Allocation Group	Group Description	Participant Count	Estimated Benefit Liability	Estimated Benefits Covered by Plan Assets	Estimated Benefits NOT Covered by Plan Assets
1	Return of Employee Contributions	0	0	0	0
2	Retirees and Active/Vested Terms who reached their Normal Retirement Date	1,382	127,679,382	84,291,881	43,387,501
3	Active/Vested Terms who reached their Early Retirement Date	639	38,061,390	0	38,061,390
4	Active/Vested Terms prior to Early Retirement Date	703	13,991,975	0	13,991,975
	Totals:	**2,724**	**179,732,747**	**84,291,881**	**95,440,867**

Funding Percentage - Total Plan - Lump Sum Basis (4.19%):	*47%*
Flat Percent Decrease to All Benefits to Fully Fund:	*53%*

Assumptions and Notes:

- Estimated benefit liabilities are determined assuming all participants would receive a lump sum payment from the Plan as of July 1, 2017. Data is based on the July 1, 2016 valuation census projected to July 1, 2017. Liabilities are valued using the March 2017 IRS segment interest rates (effective discount rate is approximately **4.19%)** and the RP-2014 mortality tables with generational improvement scale MP-2016 for males and females.

- Assets are based on **March 31, 2017 market value, projected to July 1, 2017 based on 6.50% return**.

- Allocation groups are determined by Section 10.2 of the Plan document executed on January 30, 2017. Outside legal counsel should review the priority of the allocation groups since The Angell Pension Group, Inc. cannot render legal advice.

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St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT D: Estimated Funded Liability - Ongoing Funding Basis (6.50%)

Projected Liability to Settle Benefit Obligations as of July 1, 2017

Allocation Group	Group Description	Participant Count	Estimated Benefit Liability	Estimated Benefits Covered by Plan Assets	Estimated Benefits NOT Covered by Plan Assets
1	Return of Employee Contributions	0	0	0	0
2	Retirees and Active/Vested Terms who reached their Normal Retirement Date	1,382	104,767,689	84,291,881	20,475,808
3	Active/Vested Terms who reached their Early Retirement Date	639	28,384,171	0	28,384,171
4	Active/Vested Terms prior to Early Retirement Date	703	9,038,192	0	9,038,192
	Totals:	**2,724**	**142,190,052**	**84,291,881**	**57,898,171**

Funding Percentage - Total Plan - Ongoing Funding Basis (6.50%):	*59%*
Flat Percent Decrease to All Benefits to Fully Fund (6.50%):	*41%*

Assumptions and Notes:

- Estimated benefit liabilities are determined assuming the Retirement Plan will remain ongoing and benefit payments will be paid from the Trust. The long term rate of return on investments of the Trust are expected to be **6.50%**, net of expenses. Data is based on the July 1, 2016 valuation census projected to July 1, 2017. Liabilities are valued using the long term rate of return on investments of 6.50% and the recently published RP-2014 mortality tables with generational improvement scale MP-2016 for males and females.

- Assets are based on **March 31, 2017 market value, projected to July 1, 2017 based on 6.50% return.**

- Allocation groups are determined by Section 10.2 of the Plan document executed on January 30, 2017. Outside legal counsel should review the priority of the allocation groups since The Angell Pension Group, Inc. cannot render legal advice.

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St. Joseph Health Services of Rhode Island Retirement Plan

EXHIBIT E: Projection of Minimum Funding Requirements Under ERISA

Plan Year	7/1/2017	7/1/2018	7/1/2019	7/1/2020	7/1/2021
Rate of Return Assumed	6.50%	6.50%	6.50%	6.50%	6.50%
Market Value of Assets (inc. receivables)	$84,300,000	$91,700,000	$99,900,000	$108,800,000	$119,200,000
Funding Target Liability	$148,000,000	$148,900,000	$149,600,000	$149,500,000	$148,500,000
At-Risk	No	Yes	Yes	Yes	Yes
At-Risk Funding Target Liability	$148,000,000	$150,400,000	$152,600,000	$158,700,000	$160,600,000
Funding Shortfall to be Amortized	$63,700,000	$58,600,000	$52,700,000	$49,800,000	$41,300,000
AFTAP	56.96%	61.00%	65.48%	68.59%	74.26%
Target Normal Cost (PBGC Premiums)	$1,596,000	$1,601,000	$1,608,000	$1,604,000	$1,599,000
Target Normal Cost (Expenses)	$110,000	$110,000	$110,000	$110,000	$110,000
Shortfall Amortization	$10,522,000	$10,867,000	$11,197,000	$12,265,000	$12,620,000
Minimum Required Contribution (MRC)	**$12,228,000**	**$12,578,000**	**$12,915,000**	**$13,979,000**	**$14,329,000**
Effective Interest Rate:	6.08%	5.88%	5.67%	5.49%	5.34%

Assumptions and Notes:

- Projections above assume the Retirement Plan becomes subject to ERISA and the minimum funding requirements effective July 1, 2017. The projections are based on a calendar year measurement period for illustration purposes only.

- Assets are based on **March 31, 2017 market value** and 6.50% assumed rate of return. Minimum required contributions are assumed to be paid mid-year.

- PBGC premiums are assumed to be projected for a given year and included in the Target Normal Cost. PBGC premiums are assumed to increase by 3% inflation from the current required levels.

- Liabilities are measured based on the 25-year average segment rates under HATFA (assuming future segment rates remain constant with March 2017 rates), utilizing RP-2014 mortality tables with generational improvement scale MP-2016 for males and females, and an assumed increase of 5% to measure at-risk liabilities.

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