IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
	x	
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
	x	
	x	(Jointly Administered)
Debtors.[1]	x	

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND AMICI CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE MASSACHUSETTS MEDICAL SOCIETY IN SUPPORT OF ALLOWANCE OF MOTION OF DR. STEVEN BBUYE TO DETERMINE APPLICABILITY OF THE AUTOMATIC STAY

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY[2]

The American Medical Association ("AMA"), is an Illinois nonprofit corporation, has no parent corporations, and does not issue stock. Founded in 1847, the AMA is the largest professional association of physicians, residents, and medical students in the United States. Its members practice in all fields of medical specialization in all states and in the District of Columbia. The AMA is dedicated to promoting the art and science of medicine and the betterment of public health. The AMA engages in advocacy efforts to support its mission by representing physicians with a unified voice in courts and legislative bodies nationwide.

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 2811 McKinney Avenue, Suite 300, Dallas, Texas 75204.

[2] In accordance with Federal Rule of Bankruptcy Procedure 8017(a)(4)(D), *Amici* certify that (1) *pro hac vice* attorney authored this proposed brief as *pro hac vice* attorney for *amici curiae* and no counsel for any other interested party authored, in whole or in part, the proposed brief; (2) no other interested party or counsel for any other interested party contributed money to fund preparing or submitting this brief; and (3) no person other than the *amici curiae*, its members, or its counsel contributed money that was intended to fund preparing or submitting the brief.

The Massachusetts Medical Society ("MMS"), is a Massachusetts nonprofit corporation, has no parent corporations, and does not issue stock. Founded in 1781, MMS is the oldest continuously operating medical society in the United States. The MMS is a statewide professional association of physicians and medical students with representation in the AMA House of Delegates. The MMS is dedicated to advancing medical knowledge, elevating the practice of medicine, improving patient care, and promoting public health. Through advocacy, education, and physician leadership, the MMS regularly engages in legislative, regulatory, and legal efforts affecting the practice of medicine and the delivery of health care in Massachusetts.

The AMA and MMS join in filing this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and State Medical Societies ("Litigation Center"). The Litigation Center is a coalition of the AMA and the medical societies of each state and the District of Columbia formed to represent the interests of the medical profession in the courts. The Litigation Center brings lawsuits, files *amicus curiae* briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians and the health of the public.

Amici share a commitment to promoting the health of the public, which includes a substantial interest in ensuring that the Chapter 11 bankruptcy proceedings at bar do not threaten or disrupt patient access to continuing care by destabilizing the practice of medicine. The consequences of the financial distress of Steward Health Care System, LLC ("Debtor" or "Steward"), formerly one of the nation's largest operators of health care delivery networks, directly affect the interests of countless patients, physicians, hospitals, and courts throughout the nation. In addition to the motion at bar (Dkt. No. 6373), this Court's docket reflects voluminous filings in litigation concerning Steward's failure to fund the medical malpractice liability

insurance coverage under its integrated captive insurance and risk management structure in accordance with its obligations under pre-petition contracts insuring physicians and other health care providers under that structure and the comprehensive reorganization Operating Framework established by this Court's orders, including the Insurance Continuation Order (Dkt. No. 611) and Final Order (Dkt. No. 625).[3] *Amici* join in filing this brief to provide the Court with the perspective of organized medicine and to address the broader implications on public health arising from piecemeal adjudication of medical malpractice actions covered under Steward's integrated captive insurance and risk management structure rather than within the centralized process supervised by this Court, which are relevant to the disposition of the motion under consideration.

[3] Documents previously filed in these proceedings are voluminous and are not attached hereto unless otherwise indicated but will be made available upon request.

Applicants AMA and MMS therefore respectfully request leave to file the attached *amicus curiae* brief in support of allowance of the Motion of Dr. Steven Bbuye to Determine Applicability of the Automatic Stay.

Dated: May 27, 2026

Respectfully submitted,

CAPPLIS, CONNORS, CARROLL & ENNIS, PC

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CERTIFICATE OF SERVICE

I certify that on the 27th day of May 2026, a true and correct copy of the above and foregoing was served upon all parties via the Court's electronic case filing system (ECF).

ROSS SPENCE, PC

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IN THE UNITED STATES BANKRUPTCY COURT
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In re:	x	Chapter 11
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
Debtors.[1]	x	(Jointly Administered)

AMICUS CURIAE BRIEF

INTRODUCTION

In the latter half of the twentieth century, important social institutions providing critical public services expanded from standalone operations into interdependent enterprise systems. With increasing institutional interdependence, the collapse of a single institution posed novel risks of widespread and far-reaching economic and social harm. As a result, policymakers nationwide developed institutional, financial, statutory, and regulatory frameworks designed to protect the public and manage systemic instability by preserving institutional continuity and mitigating financial harm. Congress enacted the Bankruptcy Reform Act of 1978 ("Bankruptcy Code") to establish a court supervised centralized process for the equitable and efficient allocation and administration of creditor claims arising from financial losses caused by the insolvency of a person or business. See generally 11 U.S.C. § 101, et seq. Similarly, since the 1980's the Commonwealth of Massachusetts has adopted a series of medical malpractice statutory and regulatory measures ("Malpractice Measures") to stabilize the practice of medicine and ensure patient access to continuing care in a health care system threatened by physician

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retention concerns resulting from the rising cost and uncertain availability of malpractice insurance. See generally G. L. c. 231, §§ 60B-60L (codifying requirements for litigating malpractice actions against providers of health care); G.L. c. 112, § 2 (codifying physician malpractice insurance requirements); 243 C.M.R. § 2.07(16) (setting forth malpractice insurance conditions for practice of medicine). Although enacted in different contexts, both actions protect the public from a cascade of harmful consequences and work together by mitigating economic losses. These objectives ultimately converged in the bankruptcy proceedings at bar, which inseparably intertwine the financial distress of a multi-state hospital operator with the piecemeal adjudication of medical malpractice actions covered under its integrated captive insurance and risk management structure.

In 1985, the Roman Catholic Archdiocese of Boston ("RCAB") established the nonprofit Caritas Christi Health Care System ("Caritas") to consolidate and manage existing Catholic community hospitals throughout Massachusetts.[2] Under its centralized administration, Caritas preserved patient access to continuing care and the delivery of health care within economically vulnerable communities to become one of the largest providers of community-based health care in New England.[3] By 2006, however, Caritas faced mounting operational costs, declining reimbursement margins, substantial capital demands, and increasing financial pressures from its pension obligations.[4] Caritas hospitals provided critical health care services in a large number of Massachusetts communities by offering convenient access to emergency and routine care and by employing thousands of workers.[5] Consequently, rather than pursue bankruptcy, RCAB and the

[2] See Exhibit A attached hereto containing a true and accurate copy of Report of Martha Coakley (March 6, 2008) containing a true and accurate copy of https://www.mass.gov/doc/20080306caritasreportattachment2pdf/download.
[3] See id.
[4] See id.
[5] See id.

Massachusetts government worked to find a buyer to infuse capital needed to avoid the hospital closures and workforce disruption, while initially preserving the hospitals' Catholic identity.[6] On November 8, 2011, private equity firm Cerberus Capital Management acquired the Caritas system and converted it into a for-profit entity rebranded as Steward Health Care System, LLC.[7] Eventually, Steward expanded beyond the original Massachusetts hospitals to become the largest private physician-owned for-profit healthcare network in the United States by absorbing for-profit hospitals and physician practices across multiple states.[8]

Meanwhile, Movant and other physicians and health care providers rendered patient care unaware that corporate mismanagement would later deprive them of the benefits of their medical malpractice liability insurance coverage under Steward's integrated captive insurance and risk management structure.[9] Acting pursuant to its Operating Framework, this Court minimized the loss of community-based health care and salvaged the majority of Steward-affiliated hospitals in Massachusetts by approving sales to several other operators, including Lifespan of Massachusetts, Inc. ("Lifespan"), (Dkt. No. 2520) (as supplemented on September 30, 2024 (Dkt. No. 2721)), and BMC Community Hospital Corporation ("BMC") (Dkt. 2610). Against that background, piecemeal adjudication of Debtor-Insured Malpractice Actions forces physicians and other healthcare providers to litigate malpractice claims without the benefit of funded medical malpractice liability insurance to pay their defense costs, settlement agreements, adverse judgment awards, or indemnification. This threatens the health of the public, patient access to continuing care, and the stable practice of medicine by exposing health care providers

[6] See id.
[7] See Exhibit B attached hereto containing a true and accurate copy of Scot Landry, *Opinion*, THE PILOT (Jan. 14, 2011), https://thebostonpilot.com/article.php?ID=12838.
[8] See Exhibit C attached hereto containing a true and accurate copy of Jessica Bartlett et al., *Steward Health Care raided the coffers of its in-house malpractice insurer, leaving claimants, doctors in limbo*, BOSTON GLOBE (Nov. 25, 2024), https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/
[9] See id.

to personal liability, which impairs physician recruitment, retention, and workforce stability. It also undermines this Court's Operating Framework and Steward's reorganization by impeding physician participation necessary to preserve the continued operation of Steward-affiliated hospitals and physician practices following the reorganization process. Accordingly, this Court should extend the automatic stay for the benefit of nondebtors insured under Steward's integrated captive insurance and risk management called upon to defend Debtor-Insured Malpractice Actions to prevent harm to the health of the public in affected communities while this Court resolves malpractice insurance funding and liability obligations during the reorganization process.

ARGUMENT

I. This Court should exercise its discretion to extend the automatic stay to Debtor Covered Malpractice Actions.

Reorganization under Chapter 11 permits a debtor to keep assets through a centralized reorganization process involving restructuring the debtor's obligations for efficient and equitable distribution of estate assets among creditors. It also preserves going concern value, avoids the destructive consequences of forced liquidation, protects jobs, maximizes creditor recoveries, and prevents the inefficiencies and inequities associated with fragmented creditor action and piecemeal adjudication of claims. Congress enacted Chapter 11 bankruptcy to protect the public from the economic chaos that can result from the financial collapse of important social institutions. The automatic stay reflects this goal by safeguarding estate assets by channeling allocation and administration of competing creditor claims through the bankruptcy court supervised centralized process to accomplish the efficient and equitable distribution of estate assets among creditors, furthering reorganization efforts, and avoiding inconsistent adjudications.

The automatic stay under Section 362(a) is one of this Court's most powerful tools for preserving estate assets necessary to effectuate reorganization. See 11 U.S.C. § 362(a). It broadly stays "the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, or other action or proceeding against the debtor that was or could have been commenced before the commencement of the case under this title, or to recover a claim against the debtor that arose" prior to the commencement of bankruptcy proceedings. 11 U.S.C. § 362(a)(1). It also stays "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate." 11 U.S.C. § 362(a)(3). In short, the automatic stay furthers reorganization by ensuring that the distribution of estate assets occurs under centralized bankruptcy court supervision for the benefit of all creditors.

Amici recognize that by its express terms, Section 362(a)(1) only stays a "proceeding against the debtor." 11 U.S.C. § 362(a)(1); accord In re S.I. Acquisition, Inc., 817 F.2d 1142, 1147 (5th Cir. 1987) (acknowledging stay benefits debtor and does not prohibit actions against non-debtors); Arnold v. Garlock, Inc., 278 F.3d 426, 435 (5th Cir. 2001) (cautioning Section 362 rarely presents valid basis to stay actions against non-debtors). Courts in this jurisdiction, however, have firmly embraced exceptions to this general rule by recognizing that the Bankruptcy Code provides pathways for extending the stay to protect third parties. The Fifth Circuit has also extended the automatic stay to nondebtors under Section 362(a)(3), which stays "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate." 11 U.S.C. § 362(a); see S.I. Acquisition, 817 F.2d at 1148. Moreover, the Fifth Circuit has expressly recognized that in "unusual circumstances" bankruptcy courts may invoke the stay against nonbankrupt codefendants. Reliant Energy Servs., Inc. v. Enron Canada Corp., 349 F.3d 816, 825 (5th Cir. 2003) (quoting A.H. Robins Co. v.

Piccinin, 788 F.2d 994, 999 (4th Cir. 1986)). "These circumstances include 1) when the nondebtor and the debtor enjoy such an identity of interests that the suit against the nondebtor is essentially a suit against the debtor, and 2) when the third-party action will have an adverse impact on the debtor's ability to accomplish reorganization." In re Zale Corp., 62 F.3d 746, 761 (5th Cir. 1995).

Accordingly, Texas bankruptcy courts have exercised their general discretionary power under Section 105 in the interest of justice and in control of their dockets to enjoin proceedings against nondebtors when necessary to carry out the provisions of the Bankruptcy Code. See 11 U.S.C. § 105; In re Divine Ripe, L.L.C., 538 B.R. 300, 311 (Bankr. S.D. Tex. 2015). This Court explained that the two-step inquiry requiring the proponent of extending the stay to establish "an identity of interest between the debtor and the non-debtor, and then evaluate whether the circumstances warrant exercising the 'general discretionary power . . . to stay proceedings in the interest of justice and in control of their dockets.'" Id. at 309 (alternation in original) (quoting Wedgeworth v. Fibreboard Corp., 706 F.2d 541, 544, 545 (5th Cir. 1983)). It also emphasized that "the proper use of this discretionary power requires weighing competing interests and maintaining an even balance." Id. Accordingly, Texas bankruptcy courts have found that circumstances establishing an identity of interest include formal contractual indemnification agreements such as in Divine, 538 B.R. at 299, shared legally binding liability agreements as in In re Meyerland Co., 82 B.R. 831 (Bankr. S.D. Tex. 1988), and alter ego relationships in In re Ryan, 443 B.R. 395 (Bankr. N.D. Tex. 2010). Texas bankruptcy courts have also found that a third-party action will have an adverse impact on the debtor's ability to accomplish reorganization if allowing the action to proceed would threaten estate assets, undermine the efficient and equitable distribution of estate assets among creditors, interfere with reorganization

efforts, or create inconsistent adjudications. See In re Kevco, Inc., 309 B.R. 458, 468 (Bankr. N.D. Tex. 2004).

Piecemeal adjudication of medical malpractice claims covered under the Debtors' integrated captive insurance and risk management structure subverts the fundamental policy objectives underlying the Bankruptcy Code and the Malpractice Measures. See generally, 11 U.S.C. § 101, et seq.; G. L. c. 231, §§ 60B-60L; G.L. c. 112, § 2; 243 C.M.R. § 2.07(16). Unlike most commercial bankruptcies, the Steward bankruptcy sits at the intersection of the practice of medicine, patient access to continuing care, and the health of the public nationwide.[10] The Debtor-Insured Malpractice Actions satisfy the criteria needed to establish unusual circumstances warranting the exercise of discretion. In the Movant's case pending in the Plymouth Superior Court, after Steward commenced these proceedings, all payment of insurance funded defense costs and settlement funding stopped. This forced Movant to personally pay for defense costs and exposed his personal assets to enforcement of the settlement. The motion at bar presents representative bellwether facts establishing why this Court should extend the automatic stay for the benefit of nondebtors insured under Steward's integrated captive insurance and risk management structure.

Extending the automatic stay to adjudication of medical malpractice actions covered under Steward's integrated captive insurance and risk management structure ("Debtor-Insured Malpractice Actions"), is vital to preventing the disruption of patient access to continuing care and destabilization of the practice of medicine during Steward's reorganization process. Piecemeal adjudication of Debtor-Insured Malpractice Actions directly implicates Sections

[10] See Exhibit D attached hereto containing a true and accurate copy of Examining the Bankruptcy of Steward Health Care: How Management Decisions Have Impacted Patient Care: Hearing Before the S. Comm. On Health, Ed., Labor, and Pensions, 108th Cong. (2024) (discussing impact of Steward's financial collapse on delivery of health care).

362(a)(1) and 362(a)(3). Steward's failure to fund the medical malpractice liability insurance coverage under its integrated captive insurance and risk management structure in accordance with its judicial and contractual obligations gives rise to an identity in interest and constitutes an exercise of control over property of the estate. Moreover, piecemeal adjudication of Debtor-Insured Malpractice Actions outside this Court's supervision frustrates the Operating Framework it established to preserve estate assets, insurance proceeds, and cash collateral necessary to support the continued operations of hospitals during Steward's reorganization. Extending the stay to adjudication of Debtor-Insured Malpractice Actions is consistent with bankruptcy court jurisprudence, supported by the text of the Bankruptcy Code, furthers the protective purposes of the automatic stay, and facilitates the efficient and equitable allocation and administration of creditor claims necessary for reorganization. Accordingly, this Court should exercise its discretion pursuant to Section 105 to extend the automatic stay for the benefit of nondebtors insured under Steward's integrated captive insurance and risk management structure called upon to defend Debtor-Insured Malpractice Actions.

II. Piecemeal adjudication of Debtor-Insured Malpractice Actions outside this Court's supervision subverts the objectives under the Malpractice Measures.

The Malpractice Measures recognize that medical malpractice liability differs from ordinary disputes involving liability insurance coverage because unlimited, uninsured malpractice exposure impairs physician recruitment, retention, and workforce stability, thereby threatening patient access to continuing to care. Massachusetts promoted the health of the public without compromising the delivery of health care by ensuring that injured patients receive compensation while allowing physicians and hospitals to continue practicing with protection from existential financial exposure through early claim evaluation and resolution procedures, stable insurance relationships, coordinated defense obligations, enforceable settlements and

judgments, and predictable indemnification protections. See generally G. L. c. 231, §§ 60B-60L; G.L. c. 112, § 2; 243 C.M.R. § 2.07(16). Yet, Steward's bankruptcy has threatened patient access to continuing care and destabilized the practice of medicine and with resulting harmful impacts to the health of individuals and of the public as a whole that Massachusetts sought to avoid through its Malpractice Measures.

In 2012, around the same time Steward acquired the Caritas system, Massachusetts expanded the Malpractice Measures by enacting Section 60L.[11] See G. L. c. 231, § 60L. Intended to promote early settlement of medical malpractice claims, Section 60L encourages the economical and efficient resolution of medical malpractice claims, reduces litigation costs, conserves judicial resources, and alleviates strain on health care providers and the health care delivery system. To accomplish these objectives, Section 60L requires parties to engage in mandatory prelitigation investigation, notice, and exchange of information. Accordingly, claimants must serve a health care provider with a "notice of intent to file a claim" at least 180 days before filing suit, provide details about the factual and legal bases for the claim basis, applicable standard of care, how the breach caused the injury, and allow access to medical records related to the claim. G. L. c. 231, § 60L (a)-(e). Likewise, it provides that a health care provider "shall" respond in writing providing the details about the factual and legal bases for the defense. G. L. c. 231, § 60L (g). The Massachusetts Supreme Judicial Court interpreted Section 60L to allow injured patients to pursue claims against insurers and claims facilitators who fail to make a prompt, fair, and equitable settlement offer during or after the six-month notice period. See Hopkins v. Liberty Mut. Ins. Co., 434 Mass. 556 (2001). Massachusetts courts recognize that Section 60L's mandatory disclosure of the factual and legal bases for claims and defenses

[11] See Exhibit E attached hereto containing a true and accurate copy of G.L. c. 231, § 60L.

furnishes the parties with detailed information sufficient to establish when liability becomes "reasonably clear," warranting settlement. Silva v. Norfolk & Dedham Mut. Fire Ins. Co., 91 Mass. App. Ct. 413 (2017); Gore v. Arbella Mut. Ins. Co., 77 Mass. App. Ct. 518 (2010). Consequently, the Massachusetts Superior Courts maintain heavy medical malpractice dockets overseeing all aspects of medical malpractice litigation, including investigation, discovery, adjudication, settlement, and enforcement.

Unlike many jurisdictions, Massachusetts conditions the practice of medicine on a physician's participation in mandatory medical malpractice liability insurance coverage. See G.L. c. 112, § 2.[12] Accordingly, the statutory objectives of Section 60L necessarily assume the existence of funded malpractice liability insurance coverage mandated under Section 2. Resolution of medical malpractice claims commenced during the proceedings at bar cannot occur before this Court determines the existence and amount of estate assets available for the funding of Steward's insurance obligations for Debtor-Insured Malpractice Actions. Without this information the parties lack the ability to meaningfully evaluate claims or engage in the good-faith settlement process contemplated under Section 60L.

Steward's failure to fund its insurance obligations to provide payment for defense costs, settlements, adverse judgments, and indemnification undermines the Malpractice Measures. The lack of funded insurance eliminates many of the statutory and regulatory risk-allocation protections established under Section 60L and Section 2, including, *inter alia*: providing compensation to injured patients; lowering malpractice costs; encouraging early and economical evaluation and settlement of claims involving clear-liability; providing leverage in settlement negotiations; conserving judicial by limiting unnecessary litigation; preventing waste of personal

[12] See Exhibit F attached hereto containing a true and accurate copy of G.L. c. 112, § 2.

assets on litigation; reducing exposure of personal assets to cover default, excess, or catastrophic adverse judgments; avoiding payment of tail coverage or substitute coverage; offering personal and professional stability during pending litigation; eliminating the harmful consequences of prolonged unresolved litigation on licensure requirements and professional reputation; and providing the ability to practice medicine without existential financial uncertainty. In turn these conditions impair physician recruitment, retention, and workforce stability, which harm the health of the public and subvert the very objectives of the Malpractice Measures.

The failure to fund the insurance covered under Steward's integrated captive insurance and risk management structure also negatively impacts the replacement operators now managing Steward-affiliated hospitals. For example, on April 14, 2026, after learning that Steward's captive insurer was severely underfunded, Lifespan filed *Lifespan of Massachusetts, Inc.'s Motion for Relief From the Automatic Stay to Allow for the Setoff of Mutual Obligations if and to the Extent that Recoupment is not Available* (Dkt. No. 6472).[13] Lifespan hired physicians and other medical staff who formerly practiced at the Steward-affiliated hospitals it purchased. See id. Lifespan emphasized that providing continuing malpractice insurance coverage was "necessary to recruit and retain physicians, who are essential to the hospital's operations" during reorganization. Id. Lifespan represented to this Court that Steward has allegedly failed to fulfill its obligations under the terms of the sale to continue to provide physicians and medical staff with malpractice liability insurance coverage. See id. Lifespan argued that these circumstances forced it to assume unexpected expenses exceeding five million dollars to procure liability insurance coverage to protect its physicians and medical staff who were formerly covered under

[13] See Exhibit G attached hereto containing a true and accurate copy Docket Number 6472.

Steward's integrated captive insurance and risk management structure.[14] See id. Lifespan moved for relief from the automatic stay to allow it "to set off mutual obligations if and to the extent that recoupment is not available." Id. This unanticipated expense has greatly diminished the value of the sale to Lifespan and adversely affected continued operation of its Steward-affiliated hospitals.

Steward's failure to fund the insurance covered under its integrated captive insurance and risk management structure is placing significant strain on the physicians insured through that structure. Massachusetts physicians who remained practicing at Steward-affiliated hospitals after the transition to new operators report devastating consequences due to the gap in continued malpractice liability insurance coverage.[15] Physicians are deprived of the ability to comply with the requirements of Section 60L to review and evaluate the merits of claims unless they can afford to personally retain defense counsel and experts.[16] In cases of cases of clear liability, this also presents ever greater risk of extreme exposure of personal assets.[17] Many have been made to bear the great expense of obtaining tail coverage for potential claims arising from their Steward-affiliation, despite having previously paid for coverage during that time.[18] Physicians like Movant are being drawn in to litigation seeking to hold them personally responsible for payment of settlements Steward authorized by exercising its exclusive right to settle pending lawsuits.[19] Worse, at least one Massachusetts physician is facing a trial in June 2026 without insurance to

[14] See supra note 3 and Ex. C (Bartlett). It has been widely reported that BMC likewise advised that it would provide ongoing malpractice liability coverage to physicians who continued providing care at the Steward-affiliated hospitals it acquired. See id.
[15] See Exhibit H attached hereto containing true and accurate copies of Physician Affidavits.
[16] See id.
[17] Following the COVID-19 pandemic, courts in Massachusetts and across the nation have experienced an explosion of multimillion dollar verdicts reaching tens of millions of dollars and even as high as 80 million dollars. See Exhibit I attached hereto containing true and accurate copies of Excess Judgments.
[18] See id.
[19] See id.

indemnify him for defense costs or any potential adverse judgment. See id. Such instability threatens the objectives underlying the Bankruptcy Code and the Medical Malpractice Acts, both local and systemic health care delivery, the stable practice of medicine, patient access to continuing care, and the health of the public.

III. Adjudication of Debtor-Insured Medical Malpractice Actions outside this Court's supervisions is causing devastating consequences for physicians in Massachusetts and throughout the country.

Unsurprisingly, the Massachusetts Superior Court docket reflects numerous cases mired in uncertainty arising from piecemeal adjudication of Debtor-Insured Malpractice Actions outside this Court's supervision. The proceedings at bar have also exposed physicians and their defense counsel, already deprived of funding, payment, and reimbursement, to ongoing litigation risking mounting defense costs, settlements, and adverse judgments. Without the automatic stay, they have also encouraged plaintiffs' attorneys, desperate to obtain some guidance or relief, to draw physicians into litigating ancillary issues despite the practical inability of such proceedings to produce meaningful resolutions outside the bankruptcy court's supervision. Steward's failure to fund the insurance covered under its integrated captive insurance and risk management structure prevented attorneys on both sides from effectively mounting, adjudicating, or settling medical malpractice actions. Consequently, the Massachusetts trial and appellate courts are inundated with motions seeking how to address unfunded settlement agreements,[20] withdrawal

[20] See Exhibit J attached hereto containing a true and accurate copy of the referenced order and motion. In Stellar, the trial court refused defendant physician's request to vacate the settlement agreement and to place this case back on the trial list. Rather, the trial court entered an order enforcing the settlement agreement against the defendant physician reasoning that the defendant physician "has his own litigation rights" for indemnification. See id.

from representation,[21] and discovery requests.[22] See, e.g., Barrett v. Stellar, Dkt. No. 1784CV00524 (Middlesex Super. Ct. Feb. 21, 2017) (order enforcing unpaid settlement against physician); Cappiello v. Bbuye, Dkt. No. 983CV00842 (Plymouth Super. Ct. Aug. 5, 2019) (order enforcing unpaid settlement against physician); id. (moving to withdraw citing failure pay legal defense costs and attorneys' fees); Kelly v. Raju, Dkt. No. 2483CV00859 (Plymouth Super. Ct. Oct.15, 2024) (moving to compel disclosure of whether meaningful malpractice insurance coverage existed). Some Massachusetts courts are even boldly ignoring this Court's automatic stay altogether.[23] Richardson v. Dressel, Dkt. No. 2481CV00123 (Middlesex Super. Ct. Jan. 17, 2024) (denying motion to sever and allowing discovery).

The Steward bankruptcy has placed physicians called upon to defend Debtor-Insured Malpractice Actions in financial peril. They are exposed to personal liability for payment of unfunded defense costs and attorneys' fees, settlements, and adverse judgments. They must expend personal assets to hire attorneys to assist them in evaluating how to proceed and purchase tail coverage for themselves. In addition to these economic harms, the lack of insurance funding

[21] See Exhibit K attached hereto containing a true and accurate copy of the referenced orders and motions. Exhibits filed in the proceedings are voluminous and are not attached hereto but will be made available upon request. In Bbuye, the trial court allowed plaintiff's motion to enforce the settlement against Movant. See id. After the trial court also denied Movant's counsel's motion to withdraw, counsel appealed, and the Massachusetts Appeals Court stayed the appeal pending this Court's action on the motion at bar. See Exhibit L attached hereto containing a true and accurate copy of the Massachusetts Appeals Court docket sheet. Documents filed in the Massachusetts Appeals Court proceedings are voluminous and are not attached hereto but will be made available upon request.

[22] See Exhibit M attached hereto containing a true and accurate copy of the referenced order and motion. In Raju, Plaintiff filed a motion seeking disclosure of the availability of a defendant Debtor Insured Physician's insurance coverage to satisfy any adverse judgment award. Plaintiff argued that the proceedings at bar severely impaired Steward's failure to satisfy its funding obligations and its captive insurer's financial ability to fund defense, indemnification, and settlement obligations. See id. Plaintiff contended in light of continued assertion of solvency, the tripartite relationship among insurer, insured, and defense counsel entitled disclosure of whether meaningful coverage existed. See id.

[23] See Exhibit N attached hereto containing a true and accurate copy of the referenced order and motion. In Dressel, after this Court allowed a motion for relief from the automatic stay brought by a plaintiff alleging claims against a Steward-affiliated hospital and a non-Steward-affiliated physician codefendant to allow litigation to proceed only against the non-Steward-affiliated physician codefendant. See id. Remarkably, the trial court denied plaintiff's subsequent motion to sever litigation of the claims against the Steward-affiliated hospital and allowed the matter to proceed to discovery against both the non-Steward-affiliated physician codefendant and the Steward-affiliated hospital, in violation of this Court's automatic stay. See id.

harms physician wellbeing due to its devastating personal consequences. Physicians endure psychological strain, reputational harm, and potentially ruinous financial exposure threatening personal and family assets. These facts directly affect Steward's bankruptcy proceedings and the general health of the public because the continued operation of former Steward-affiliated hospitals depends upon retaining credentialed physicians who already maintain patient panels, hospital privileges, specialty coverage responsibilities, referral relationships, and familiarity with institutional operations.

Unless this Court extends the protection of the automatic stay to adjudication of Debtor-Insured Malpractice Actions, the proceedings at bar not only threaten Steward's own reorganization, but also the health of the public, local and systemic health care delivery, the stable practice of medicine, and patient access to continuing care, in a myriad of harmful ways. Significantly, the personal exposure arising from unfunded litigation defense costs, settlements, adverse judgments awards, and indemnification place the Massachusetts physician workforce in serious jeopardy. It deters physicians from continuing to practice at, or considering employment with, former Steward-affiliated hospitals, which is necessary to support the continued operations of hospitals during Steward's reorganization, because such employment exposed them to unacceptable personal financial risk. It presents a risk of Massachusetts physicians declining or leaving employment at a former Steward-affiliated hospitals, reduced or may reduce clinical involvement, declined or may decline high-risk specialties, avoided or may avoid emergency call obligations, based on their discovery that they cannot rely on their Steward insurance coverage to fund defense costs, settlements, adverse judgments, and indemnification.

The motion at bar concretely illustrates these systemic concerns. While Movant faces exposure of his personal assets in pending litigation, Movant's circumstances are not isolated and

illustrate why these issues extend beyond an individual dispute and instead implicate broader interests of countless patients, physicians, hospitals, and courts suffering the practical consequences of prolonged uncertainty surrounding the availability of Steward insurance funding while these proceedings are pending. Piecemeal adjudication of Debtor-Insured Malpractice Actions outside this Court's supervision frustrates the objectives of Chapter 11 and this Court's Operating Framework by undermining the efficient and equitable distribution of estate assets among creditors. Absent coordinated application of the automatic stay, it will also threaten estate assets, undermining the efficient and equitable distribution of estate assets among creditors, interfering with reorganization efforts, and creating inconsistent adjudications. See Kevco, 309 B.R. at 468. The cumulative effect of piecemeal adjudication of the Debtor-Insured Malpractice Actions also undermines the very goals of the Medical Malpractice Acts. In this context, application of the automatic stay to Debtor-Insured Malpractice Actions not only serves as a protection for Debtor, but also advances core objective of the Bankruptcy Code and the interests of the health of the public, while fundamentally reinforces the integrity of the reorganization process by facilitating this Court's supervision over Steward's reorganization.

CONCLUSION

For all the forgoing reasons and those stated in the pleadings filed by Movant Steven Bbuye, M.D., this Court should exercise its discretion to extend the automatic stay to adjudication of medical malpractice actions covered under the Debtors' integrated captive insurance and risk management structure for the benefit of nondebtors insured under that structure to protect patient access to continuing care, the stable practice of medicine, the health care delivery system, and the health of the public.

Dated: May 27, 2026

Respectfully submitted,

CAPPLIS, CONNORS, CARROLL & ENNIS, PC

By: */s/ Sean E. Capplis*

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CERTIFICATE OF SERVICE

I certify that on the 27th day of May 2026, a true and correct copy of the above and foregoing was served upon all parties via the Court's electronic case filing system (ECF).

ROSS SPENCE, PC

By: */s/ Ross Spence*

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EXHIBIT A

Report of Martha Coakley

THE COMMONWEALTH OF MASSACHUSETTS
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March 6, 2008

Caritas Christi Health Care System plays a critical role as one of the largest health care systems in New England. Established in 1985, Caritas is a Catholic health care system, associated with the Archdiocese of Boston, which includes St. Elizabeth's Medical Center in Brighton, Carney Hospital in Dorchester, Good Samaritan Medical Center in Brockton, Holy Family Hospital in Methuen, Norwood Hospital in Norwood, and Saint Anne's Hospital in Fall River. Many of the services provided by its six hospitals are crucial to the communities they serve. In addition, the system plays an important role in preserving competition among hospitals in Eastern Massachusetts, which is necessary to moderate the reimbursement rates hospitals negotiate with insurers and, ultimately, the amounts insurers charge consumers.

While Caritas is not the only health care system in the Commonwealth facing significant challenges, its failure to partner with another system last year, combined with leadership and operational difficulties, have caused significant concerns about the future of the system. As part of our responsibility for overseeing the public's interest in the viability of the Commonwealth's non-profit charitable hospitals, the Attorney General's Office asked Health Strategies and Solutions, Inc. to prepare this report, which identifies key areas that must be successfully addressed by Caritas in order to become a more viable organization. The report identifies governance reform, the future of Carney Hospital, the role of St. Elizabeth's Medical Center and the operating performance of the Caritas Physician Network as priorities that need to be effectively addressed in order for the system to succeed. These recommendations are important, not only to the thousands of patients who rely on Caritas for care, but to the stability and efficiency of the Eastern Massachusetts health care system.

The most compelling priority confronting Caritas is the need for the Archdiocese of Boston to relinquish direct and indirect control over strategic, operational, and financial matters of Caritas while retaining influence only over matters of religious direction. Operating a hospital system is an extraordinarily complicated business, a recognition that has led virtually all religious organizations throughout the nation to transfer control to lay boards while in most cases maintaining a commitment to the religious principles upon which the systems were founded. Indeed, last year, the

Archdiocese approached three different national organizations about potentially assuming control of Caritas—all are lay organizations that adhere to and promote the religious principles of the Catholic faith.

It is in the best interests of Caritas that the Archdiocese transfer total control of the business of the system to an independent Board of Governors, which should have the sole authority to choose Board members and the chief executive, and to run Caritas in the manner it deems appropriate with no outside influence except on matters of religious direction. For instance, it may be appropriate for diocesan leadership to play a role in decisions regarding the nature and extent of reproductive health services offered in Caritas facilities.

We note that previous consultants to Caritas have made similar recommendations and that the Caritas Board and the Archdiocese commenced a review of the current governance structure several months ago. Proposed changes generated by the Board, and approved by the Archdiocese, were recently submitted to us. We will review those submissions and provide comments to Caritas and the Archdiocese consistent with the goal of a strong and independent governing body for Caritas.

Another priority for reform concerns one of the Caritas hospitals, Carney Hospital in Dorchester, which has been operating in a precarious position for decades and whose problems pre-exist the involvement of Caritas. The nature and extent of those problems are documented in the report. Moreover Caritas, to its credit, has retained Huron Consulting to conduct a more focused and in-depth study of Carney. We welcome that study and look forward to reviewing its findings and conclusions.

Of significant concern is that Carney has become dependent on Legislature-approved public funding to fund operations. Carney's future should be based on current community need, not on historical service lines. Accordingly, acute medical-surgical inpatient hospital care may not be the appropriate future for Carney. The growth areas of health care are almost universally found in ambulatory settings and Greater Boston has no shortage of medical-surgical inpatient beds. Moreover, there may be other inpatient specialties for which the need is far greater and upon which operational and fiscal stability may be better founded. However, any long term plan for Carney must address the availability of emergency services and involve substantial input from the Dorchester community.

The best course for St. Elizabeth's Medical Center in Brighton should be as a community teaching hospital, with a concentration in, and development of, advanced capabilities in two to three major specialties where it can be competitive. Caritas has already embraced that future and the development of its service expertise in cardiology is indicative of its potential to effectively compete in the Greater Boston marketplace.

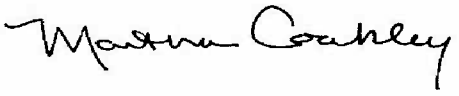
Finally, the Caritas Physician Network had an operating loss of nearly $30 million in FY 2007 and is budgeted to lose approximately $15 million in FY 2008. The Network should evaluate all physician contracts and compensation arrangements in comparison to

industry medians and implement a new compensation structure for employed physicians, with greater emphasis on physician productivity.

By addressing these priorities, the Archdiocese and Caritas management can better ensure a stable future for the health system. We now have a basis upon which my office, the public, representatives of state and local governments, and members of the health care provider and payer communities can better work with Caritas on a going forward basis. All of us will benefit from a stable and successful Caritas Christi Health Care System. With the continued commitment of the Caritas board, management, physicians and staff, and the cooperation of the Archdiocese, we have every reason to believe that the Caritas system can continue its tradition of service well into the future.

During the course of this review, Caritas management and members of its Board of Governors have worked cooperatively with representatives of Health Strategies and Solutions, Inc. and my staff and I very much appreciate their past and future dedication and hard work. I would also like to thank the physicians and employees within Caritas whose dedication during these uncertain times bodes well for the future of this very valuable resource.

Cordially,



Martha Coakley
Attorney General

EXHIBIT B

Scot Landry, *Opinion*

The Pilot

America's oldest Catholic newspaper

Responding to criticism of the Caritas Christi sale

Scot Landry OPINION FRIDAY 14TH OF JANUARY 2011

On Nov. 8, the sale of Caritas Christi Health Care to Cerberus Capital Management was completed. In the transaction, Catholic healthcare in the archdiocese now will be part of a for-profit system like St. Vincent's hospital in our neighboring Diocese of Worcester.

Since this transaction was very large and complicated, I expected that there would be some differences of opinion on how good an agreement this was, and what it meant for the long-term prospects for Catholic healthcare in the archdiocese. Most of these concerns were expressed in good faith.

However, what I didn't expect was that some would charge -- falsely -- that Cardinal Seán O'Malley and leaders at the archdiocese did not care about preserving the Catholic identity of the system. Since many presume that silence implies consent, it would be contrary to respect for the truth not to respond to such serious allegations. I hope in this column to address some of those concerns and to provide some background on the situation so that people can make a more factually accurate evaluation of what was decided and why.

I began working at the archdiocese and serving on Cardinal O'Malley's Cabinet in 2006. It was clear from my first weeks here that the viability of the Caritas Christi Health Care system was an area of grave concern. The system was carrying an unsustainable amount of debt. This debt was preventing additional borrowing at favorable interest rates, and the interest payments were limiting the amount Caritas Christi could invest in overdue renovations and in equipment upgrades. The projected amount of capital needed to keep the system competitive was staggering. At the same time, the pension fund for Caritas Christi's employees and retirees was significantly underfunded and, without a massive financial infusion to save the system, those who had and have dedicated their entire professional lives to the ministry of Catholic health care were in danger of losing some part of their retirement benefits.

The archdiocese, and Caritas Christi, faced four possible paths. One option, clearly the least desirable and the last resort, was to close the system and use the proceeds to address the pension and the debt. The three better options, in order of preference were: (1) a "go-it-alone" strategy in which it would seek investments to address the financial shortfalls, or sell elements of the system to strengthen the remaining hospitals; (2) to partner with a national Catholic healthcare system; or (3) to sell the system, ideally to an entity that would maintain its Catholic identity.

The overall goals were to keep Catholic healthcare viable as an option going forward, to preserve full pensions for those that dedicated their lives to Catholic health care ministry, to preserve jobs and health care in the communities that Caritas Christi hospitals served, and to proceed in a way where the financial difficulties at Caritas Christi couldn't jeopardize the archdiocese's parishes and other key ministries.

Cardinal O'Malley first pursued the "go-it-alone" approach. He encouraged the hiring of a talented management team at Caritas Christi who could maximize every chance to make the system viable financially. The management team did an excellent job at improving the financials; however, the staggering pension deficit and the needed renovations and system upgrades required significantly more capital than Caritas Christi could ever produce from operating surpluses, fundraising efforts or through selling portions of the system. All stakeholders eventually agreed that "going-it-alone" couldn't succeed.

Cardinal O'Malley then encouraged the investigation of all possible partnerships with a large national Catholic health care system. Some of these conversations got to the stage where concrete terms for possible deals were discussed. Again, however, the staggering pension deficit and the projected costs of system upgrades were too large for these Catholic systems to absorb and address.

After the "partnership" path was exhausted, Cardinal O'Malley supported conversations to sell Caritas Christi to a non-Catholic system, as long as the sale would address the pension deficit and the needed renovations. His preference was to find a buyer that would commit to keeping the system Catholic, but he also realized that it was possible that some options might not allow this. He definitely wanted to avoid the system closing, as St. Vincent's Hospital in New York had earlier this year, because that would clearly endanger the pensions of those who had dedicated their professional careers to Catholic healthcare within Caritas Christi, lead to those currently working in the system losing their jobs, and lead to communities losing their hospitals. He encouraged the exploration of all options so that the best possible deal for all Caritas Christi stakeholders could be reached.

On March 25, 2010, Caritas Christi announced that it had reached an agreement with Cerberus Capital Management to acquire the system. The terms called for more than $830 million of investment to satisfy Caritas Christi's pension obligations, to repay Caritas' debt, to launch capital projects and to fund immediate upgrades. It also specified that the hospitals would remain Catholic, although it provided ways for Cerberus to choose not to maintain the system's Catholic identify in the future.

Reaction to the sale terms was mixed. Several Catholic leaders recognized that, under the circumstances, this was a victory for Caritas Christi to find a partner with significant capital to invest in Caritas Christi's infrastructure, fully satisfy pension obligations, and desire to maintain the Catholic identity of the system.

Several other Catholic leaders expressed concern. Some wondered if all options to "go-it-alone" or "partner" had been attempted. Others asked what the implications of conversion to a for-profit system would mean for the quality and sustainability of care in poorer communities. Others criticized the "out-clause" that allowed Cerberus to drop the Catholic identity of the system, forecasting that a for-profit system would jettison the U.S. Bishops' Ethical and Religious Directives (ERDs) for health care as soon as they could do so, especially if the cost for exercising that clause was a relatively small payment of $25 million. Others speculated that a private equity firm like Cerberus would someday "carve up" the system's assets to provide a greater return to its investors. Others criticized the statements and actions of Caritas Christi officials throughout the process, stating that they didn't speak forcefully enough about their desire to adhere always to the ERDs and act in ways that clearly communicated that they fully supported them. A few, recently, have charged that Cardinal O'Malley didn't do enough to guarantee Catholic identity of the system.

Many of these criticisms make broad and false assumptions. In the absence of full information, some have presumed bad motives, denying any and all benefit of the doubt to Cardinal O'Malley and to the Caritas Christi management team. In fairness, some could legitimately point out that the archdiocese and Caritas Christi should have shared more information with the Catholic community and the general public to prevent those with serious concerns from drawing erroneous conclusions. I think that's a lesson learned. This article seeks to address a few of these false assumptions and provide some additional information.

The first major assumption is that there would have been another adequate or even better option available if the Cerberus transaction fell through. There wasn't a better option -- or even another acceptable option -- on the table. Cardinal O'Malley and Caritas Christi's leaders had exhausted the "go it alone" and the "partner with a Catholic healthcare system" paths. The agreement with Cerberus fully-funded the outstanding pension liability, invested hundreds of millions in upgrades and renovations, and preserved the Catholic identity of the system for at least three years. The total transaction amount was more than $830 million of investment, which is a massive infusion of capital into a system that had a tenuous future.

Would Cardinal O'Malley and all those with an interest in Catholic health care have preferred a deal that would guarantee the Catholic identity of the Caritas Christi system forever? That's undeniable. Would Cardinal O'Malley and the archdiocese have preferred Cerberus to donate a larger amount if they change the hospitals to non-Catholic status? Categorically, yes. But those options did not exist. Anyone that has been involved in a business transaction or the sale of a home realizes that there is give-and-take in any negotiation. Even with no ready alternative, this agreement produced a positive outcome for the retirees, employees and communities. I also think all can agree, even if critics' worst case scenarios come to pass, that three years of guaranteed Catholic identity is better than zero years -- something that would have occurred if the system closed or was sold to an entity that converted the hospitals immediately to secular status.

A second assumption is that Cerberus will certainly change the Catholic identity of the system or carve it up and sell its pieces to maximize the financial returns for their investors. That certainly is a theoretical possibility; however it fails to consider that the

Cerberus management team passionately and repeatedly stated that they want to maintain the Catholic identity of the system. If these hospitals are financially successful, there is no reason to conclude that Cerberus will not want to continue to run them as Catholic hospitals. That, in large part, will be determined by the patient volume at the hospitals. Those who wish to preserve Catholic health care for the long-term can have a direct impact if they encourage patients to choose the Catholic care offered at these hospitals over the region's many secular options.

Criticism of Cardinal O'Malley's involvement in this agreement also falsely assumes a few things. First, in the proposed Centene arrangement in early 2009, some have mistakenly inferred that Cardinal O'Malley was in favor of Centene before a negative public reaction led him to change his mind. The truth is that Cardinal O'Malley learned about the Centene transaction when it appeared in the Boston Globe. Cardinal O'Malley immediately expressed his concerns to the Caritas Christi management team. He then brought in the National Catholic Bioethics Center to advise him on the many complex issues involved -- a thorough inquiry that led to his concluding that the Centene arrangement could not satisfy the Ethical and Religious Directives. The deal did not go through.

Similarly, in the proposed purchase by Caritas Christi of Landmark Hospital in Rhode Island in September 2010, some falsely assumed that Cardinal O'Malley was okay with the proposed purchase and the announcement that it would be run as a secular hospital. The fact is that, as soon as he found out through an article in the Providence Journal, he immediately met with Caritas Christi management. The decision was reversed in 48 hours.

Some might wonder why the cardinal tolerated learning of these unacceptable proposed transactions in the secular press. Others might question why his response to these circumstances was handled privately with the Caritas Christi management team versus in a public way. The cardinal chose this route because he was primarily focused on strengthening the system and achieving the best option to preserve it for the future.

Other leaders may have issued a public rebuke in an effort to distant themselves. That, however, would not only have been out-of-character for the cardinal but likely would have undermined the larger goals during a time of important negotiations.

Rather than debate the methods, instead let us look at the results: Cardinal O'Malley's steady leadership and his private way of handling these situations maintained a context in which discussions toward a successful outcome were able to progress. Moreover, his leadership prevented any deal that wouldn't have been in accord with the ERDs.

In summary, it is understandable that when faithful Catholics compare the terms of the Cerberus agreement versus a hypothetical ideal, there are certainly terms that they wish were more in line of an absolute guarantee for the long-term preservation of authentic Catholic health care in our region. But compared to the real options available, one of which was possible insolvency in the face of pension obligations and the system's debt, this transaction was a solid one that at least preserves the option of Catholic healthcare going forward. It's unwise to make the perfect the enemy of the good.

Critics of this agreement generally wanted the same outcomes that Cardinal O'Malley and other leaders at the archdiocese sought. We respect those who have expressed concerns and appreciate their passionate advocacy for Catholic identity and their defense of the Catholic faith when it comes under attack. It is my hope that through providing some of the background information above, the decisions will be understood, not as a negligent betrayal of Catholic identity in health care, but as a persevering attempt to achieve the best possible outcome among the real alternatives.

Cardinal O'Malley's remarks from November 8 are a fitting way to conclude this column: "I am pleased that the process for transfer of the Caritas Christi Health Care System to Steward Health Care System LLC has been completed. We have consistently pursued the goal of preserving and enhancing Catholic health care for the greater good of the patients Caritas serves. As a result of this transaction, Caritas will have access to much needed capital for its infrastructure and programs, and also its pension obligations, while continuing to provide high quality healthcare, especially for the poor, in accord with Catholic teaching. Our prayer is that the healing ministry of Christ will endure for all people, particularly those most in need, through the continuation and enhancement of Caritas Christi Health Care."

Scot Landry is Secretary for Catholic Media of the Archdiocese of Boston.

EXHIBIT C

Jessica Bartlett, BOSTON GLOBE

Steward Health Care raided the coffers of its in-house malpractice insurer, leaving claimants, doctors in limbo

This story was reported and written by **Jessica Bartlett**, **Elizabeth Koh**, and **Liz Kowalczyk**. It was edited by **Gordon Russell**.

Published Nov. 25, 2024

When Melissa Williams looks down at her ruined right hand, all she sees is loss.

Two fingers and part of her palm have been amputated.

Gone, too, is her financial security. Williams has been unable to work regularly since 2017, when she entered a Steward Health Care hospital in Melbourne, Fla., for a common operation, and a botched IV insertion led to searing pain and a host of complications that continue today. Williams sued Steward in 2019 for what seemed an egregious case of malpractice.

Five years later, and facing $500,000 in medical bills, she hasn't seen a dollar from the hospital chain.

It is unclear why no settlement has been reached, and Steward continues to fight the case in court. But a Globe Spotlight Team review points to a possible explanation for the frustrations Williams and scores of other Steward patients have experienced. Executives at the overextended hospital chain have treated their in-house malpractice insurer, TRACO, like a piggy bank, pulling cash from it at will, and severely depleting the assets meant to cover claims of medical harm.

Indeed, Steward was so eager to spend TRACO's money that it moved the insurer from the Cayman Islands — a traditionally permissive locale for foreign investors — to Panama, where certain key regulations were even more lax. Auditors had been pushing Steward to shore up TRACO's balance sheet. But executives had other plans for the insurer's assets and believed Panama would allow them more freedom to spend, according to three Steward insiders and internal company emails.

The aggressive draining of TRACO's balance sheet has Melissa Williams wondering if she will ever be compensated for her losses. She and her 14-year-old son recently had to put their belongings in storage and move in with a friend.

"What if your lawsuit never settles?" asked Williams. "What if you never get a dime?"

Melissa Williams at Eau Gallery in Melbourne, Fla., where she is a member. (Jacob M. Langston for The Boston Globe)

At the time of TRACO's relocation to Panama, executives at Steward — then growing from its base of nine Massachusetts hospitals into the largest private for-profit health care chain in the US — had already taken millions of dollars from its insurer, whose leadership overlaps substantially with Steward's. The borrowing accelerated as Steward hemorrhaged money, with enormous IOUs from the hospital chain replacing TRACO's funds. By the end of 2023, TRACO's books showed $99 million in outstanding loans and interest, almost all of it owed by Steward. Separately, TRACO listed $176 million in "accounts receivable." Bankruptcy documents make clear that most of that sum is owed by Steward.

The real value of those IOUs today is uncertain at best, given Steward's declaration of bankruptcy in May. As of August, TRACO listed just $3.5 million in cash — an absurdly small sum when stacked against the 517 malpractice claims against Steward that are either pending, like Williams's

case, or settled but unpaid. Steward's lawyers have said the remaining claims could cost as much as $200 million to settle.

The grim financial picture means that patients who suffered from shoddy care at Steward facilities could be harmed a second time, when they are unable to collect what they're owed.

What happens when medical malpractice insurance runs dry

These Steward patients suffered from alleged misconduct or medical errors — some fatal — and have not seen settlement money. Read their stories.

Keith Wade

Lillian Malick

Kyela Pixler

At risk, too, are some of the thousands of doctors who worked for the chain and now wonder if the malpractice insurance that was supposed to be protecting them is worthless. At least one lawyer involved in suits against Steward has begun suing doctors personally, betting they have deeper pockets than the chain.

The strip-mining of TRACO and its impacts have gotten limited attention amid a larger pattern of questionable financial dealings at Steward, whose owners took hundreds of millions of dollars in payouts even as their hospitals crumbled. The firm's stunning collapse is now being investigated by a federal grand jury meeting in Boston.

Timothy Walsh, an attorney for TRACO, told the Globe that "TRACO is not insolvent as long as the debtors adhere to their obligations, which we expect them to do." TRACO's biggest debtor, of course, is Steward, which is broke.

TRACO officials declined to answer other questions. Steward representatives also declined to comment for this story.

Born in the islands

TRACO is what is called a captive insurer, a wholly owned self-insurance vehicle of the sort that many hospital systems prefer. Health systems like Steward typically pay premiums on behalf of their doctors, though some 200 Steward-affiliated doctors actually paid Steward malpractice premiums out of of pocket. The premiums are supposed to go into a pool that is used to litigate claims and pay them when necessary.

Money in the pool can be invested, ordinarily with a preference for low-risk vehicles that are easy to cash out. If the company manages its risk well and the pool grows large, some assets can be returned to the firm.

Decades ago, there was no mechanism to set up such captive insurers in the United States. So, in 1988, Steward's predecessor — Caritas Christi, which was run by the Archdiocese of Boston — incorporated TRACO in the Caymans. The name is an acronym for Tailored Risk Assurance Co.

The Caymans' reputation for permissiveness helped it become a business hub, but also landed the country on international watch lists for, among other things, failing to adequately combat money laundering. Over the last 15 years, the nation's leaders tightened things up, and today, "the regulatory structure and requirements" of the Caymans match those of European countries, said Mark E. Reynolds, president of CRICO, the group captive insurer for many Boston teaching hospitals, which was long based in the Caymans.

Panama, by comparison, has not been a beacon of respectability. As Steward finalized its bid to move TRACO there in June 2019, one international body flagged Panama as vulnerable to money laundering. Another found it susceptible to tax evasion.

Captive insurers are rarely found in Panama

The Cayman Islands, with historically lax oversight laws, has long been a hotspot for captive insurers, ranking second in the world for the number of such entities in a jurisdiction. Panama, by contrast, is ranked 52nd. TRACO is one of just six captives located there.

Rank	Country	Captives	Pct. of all captives
2	Cayman Islands	658	10.6%
52	Panama	6	0.1%

Source: Business Insurance. Notes: Data as of 2023.

JOHN HANCOCK/GLOBE STAFF

On top of that, Panama had little or no expertise in setting up and regulating companies like TRACO. The firm is one of only six captive insurers headquartered there.

Nancy Gray, who oversees captives in the region for Aon, a leading insurance consultancy, said she doesn't know why an insurer would move to Panama. Not one of her firm's 1,000-plus captive clients is located there.

The Cayman Islands "have been doing this for many years," Gray said. "There is no reason to recommend a domicile without a developed practice … [and] regulators who understand the business and have been involved for a while."

But Steward's leaders were eager to escape restrictions on how they could spend TRACO's money. They saw Panama as a sanctuary, according to Globe interviews as well as internal emails obtained by the Organized Crime and Corruption Reporting Project and shared with the Globe.

For instance, when auditors from Ernst & Young questioned whether Steward had given Panamanian officials ample notice of a change in finances, a Steward executive assured his colleagues that, unlike in the Caymans, it wouldn't matter much.

"Seems like EY [Ernst & Young] is missing the 'so what' component here," wrote Jacob Frumkin, Steward's vice president for finance. "Whether or not we did something we shouldn't have, the beauty of Panama is the 'so what' is not going to be that we're not an insurance company anymore … it's probably a discretionary fine of a $1,000 or something like that."

Perhaps the most important distinction between Panama and the Caymans was the flexibility Panama allowed TRACO in using its money. In Panama, "there is no limitation on TRACO's ability to loan or invest its assets," Frumkin explained in an email to auditors and a group of fellow executives. TRACO had to keep a balance of just $150,000 in a Panamanian bank.

In another 2019 email, Steward's chief financial officer John Doyle pushed for Steward's lawyers to produce a letter explaining TRACO's upcoming relocation. "This is needed to get EY [Ernst & Young] off of our backs re the need to fund the Cayman captive," he said.

By May of that year, TRACO just needed a physical office to complete the relocation. TRACO's president, Rubén José King-Shaw Jr., had an idea: How about his penthouse, in a swanky part of Panama City?

Rubén José King-Shaw Jr. (FIU)

The firm's local attorneys balked, saying TRACO would need a "formal office, where the authorities can go and make inspections."

King-Shaw pushed back. Less than a month later, he emailed fellow Steward executives with good news: Panama would allow TRACO to be domiciled in his penthouse.

Dr. Ralph de la Torre, Steward's CEO, was jubilant. The move was finally on.

"Yay!" he replied in an email. "Great job!!"

'Where the cash is'

Even as they plotted to move TRACO to Panama, Steward executives began stepping up the drawdown of TRACO's treasury.

In 2019, they invested $132 million of TRACO's money into Davis Hospital and Medical Center in Utah, which Steward had bought two years earlier.

Captive insurers typically invest in vehicles that are easy to cash out.

"If you needed to pay losses, to get funds for the captive, how are you going to be able to do that if you have to sell real estate?" asked Tim Slowick, who helps manage UMass Memorial Health's captive. "Hospitals aren't the easiest piece of real estate to sell."

Steward did eventually sell Davis, in 2023. But there's no evidence any of the proceeds went to TRACO. Instead, the amount TRACO listed in "investments" on its financial statements dropped by $132 million at the close of that year. And the amount TRACO said it was owed in accounts receivable jumped from $289,000 to $176 million.

Steward's bankruptcy filings say that TRACO still owns a 30 percent share in Davis, but the hospital's new owners, CommonSpirit Health, told the Globe they own it free and clear.

Steward, TRACO boards had significant overlap

TRACO, Steward's in-house malpractice insurer, was overseen by many of the same people who ran Steward, including Dr. Ralph de la Torre. That may explain why Steward repeatedly raided TRACO'S accounts. Here's what it looked like in mid-2020.

Name	TRACO position	Steward position
Dr. Ralph de la Torre	administrator	chairman and chief executive officer
Dr. Michael Callum	administrator	president, Steward Medical Group
John Doyle	treasurer	chief financial officer
Rubén José King-Shaw Jr.	president, administrator, representative	chief strategy officer
Herb Holtz	secretary, administrator	executive vice president and general counsel

Source: OpenCorporates, web archives, Steward Health Care website.

JOHN HANCOCK/GLOBE STAFF

The IOUs continued to pile up after the move to Panama, according to emails reviewed by the Globe.

In December 2020, the insurer sent $5 million to another Steward business. Another loan was drafted in 2021, this time taking $6.7 million from a TRACO

affiliate. The money was to be used to help acquire and develop a hospital in Colombia, the emails show.

“TRACO is where the cash is I am told and that is where Ralph wanted it funded from if possible,” wrote Mark Rich, then a Steward consultant and now the company’s president.

“TRACO is where the cash is I am told and that is where Ralph wanted it funded from if possible.”
—Mark Rich, now president of Steward Health Care

By that time, Steward had stopped sending the premiums it was paying on behalf of doctors to TRACO, giving the captive an IOU instead, according to one former Steward executive.

TRACO’s habit of accepting IOUs and making loans to Steward, especially given Steward’s precarity, struck others in the industry as suspect.

“If you wanted to be sneaky, you could borrow money from your captive, move it to your parent company, and the captive would be holding an asset that would be that loan,” said Dr. Eric Dickson, CEO of UMass Memorial Health, which has a captive in the Caymans. “The value of that loan if your company went bankrupt is zero. We would never do that.”

While Panama’s rules were looser than those in the Caymans, TRACO nonetheless managed to break them eventually.

Last November, a month after Panama was removed from the international “gray list” for improving its anti-money laundering and financial regulation measures, the country fined Steward $25,000. TRACO was cited for “various irregularities with the administration, mitigation and control of risks,” according to a government website. The company was also cited for “refusing to submit accounting records of its operations.”

Reached by phone, Mary Arjona, chief of the Department of Administrative Law for the insurance department in Panama, said the details are confidential. Pressed further about the country’s rules for captives, she said: “Public officials do not answer these types of questions from journalists.”

The Panamanian government declined to answer written questions posed by the Globe.

Doctors, nurses at risk

Steward has filed for bankruptcy as its finances have cratered. TRACO has denied in bankruptcy filings that it is insolvent, and Steward has sought to assure its doctors and patients that TRACO continues to cover them, paying millions of dollars in defense costs, if need be. But most of TRACO's assets are IOUs from Steward.

The companies are intertwined in many other ways. TRACO's board still includes former Steward CEO de la Torre and another top executive, Dr. Michael Callum, though the two recently stepped down from leadership at Steward.

Steward has suggested it will resolve current claims through the bankruptcy — though that may simply mean offering victims pennies on the dollar.

Many former Steward doctors are dubious of the chain's promises, partly because Steward has a history of not paying its defense counsel. Marc Edward Stewart, a lawyer from Arkansas, said in one of his cases, multiple Steward attorneys have quit over nonpayment.

A physician at St. Elizabeth's Medical Center in Brighton has been worried about being sued after one of her patients was harmed last year. Months before Steward filed for bankruptcy, she called three law firms for advice. None wanted to represent her, fearing Steward would stiff them.

The physician asked not to be named over concerns of a potential lawsuit.

As TRACO executives, King-Shaw and Callum emailed doctors two months ago to assure them that their insurance was intact. Callum stepped down from TRACO shortly afterward.

The message left some providers incredulous, including Stephen Wood, who worked as a nurse practitioner at Carney Hospital until Steward closed it in August. He and a colleague purchased their own malpractice insurance in May.

"If I were to devise a prank call, this would be a great one," Wood said. "'All your medical malpractice is run … in Panama — by the same people who ran your hospital in the ground. But you don't have anything to worry about! We will take care of it!' It's a joke."

Some lawyers, doubtful they'll ever collect from Steward or TRACO, have begun to target Steward doctors personally.

Ashton Hyde, a malpractice attorney, filed a suit against a Utah doctor and Steward over a problematic spine surgery in mid-2022. He recently refiled the lawsuit, this time only targeting the physician.

"We are going after the doctor individually and he is effectively uninsured," Hyde said. "So his personal assets are exposed."

The question of TRACO's solvency could be relevant well into the future, because malpractice victims may bring claims years after an incident.

Two health systems — Lifespan and Boston Medical Center — that each acquired two Massachusetts hospitals from Steward have taken the unorthodox step of committing to protect their new employees from past missteps, should TRACO fail to cover them.

Melissa Williams and her son, Steen Fancher, 14, try to diagnose the problem with the 3D printer at the home they are staying at in Melbourne. (Jacob M. Langston for The Boston Globe)

Melissa Williams makes ice cream at the Melbourne home where she and her 14-year-old son are staying. (Jacob M. Langston for The Boston Globe)

Solvency never measured

TRACO's troubles have drawn little scrutiny from the state agencies that oversee doctors and insurers, though Massachusetts regulations allow either the state Board of Registration in Medicine or the Division of Insurance to require insurers to prove "that funding of the entity is adequate."

Michele Campbell, a spokesperson at the Insurance Division, asserted that the agency lacks the authority to request the relevant documents from an insurer that, like TRACO, is not licensed in Massachusetts.

The Board of Registration, which licenses doctors, acknowledged in an email from spokesperson Ann Scales that it does not seek financial documents from malpractice insurers. The board pointed to the Division of Insurance as the agency that would theoretically do so.

The board also asserted in an email that TRACO has been paying all its claims – an assertion disputed by multiple attorneys whose clients have unpaid settlements.

'A bunch of loopholes'

TRACO's depleted assets and Steward's bankruptcy have left people like Yasmany Sosa in legal and financial limbo. Sosa's 35-year-old wife, Yanisey Rodriguez, died a preventable death at Steward North Shore Medical Center in Florida on Sept. 7, 2022, seven days after giving birth to their first child.

Though Steward agreed to a $4 million settlement with Sosa in March, he has yet to be paid.

The money was never going to bring his wife back, or ease his grief. But it was going to help in other ways. Without his wife's income, Sosa has had to change jobs and work longer hours, he said.

The bankruptcy has made him wonder if he'll ever get paid.

"They killed my wife, that's for starters. Second of all, they destroyed my family," Sosa said through a translator. "This has all become a bunch of loopholes, legal strategies. This really is very difficult for me ... I've already lost everything."

Stephen Wood stood outside of the closed Carney Hospital. (Suzanne Kreiter/Globe Staff)

Brendan McCarthy and Hanna Krueger contributed to this report

EXHIBIT D

Congressional Hearing September 12, 2024

Impact of Steward Bankruptcy on Patient Care

S. HRG. 118–472

EXAMINING THE BANKRUPTCY OF STEWARD HEALTH CARE: HOW MANAGEMENT DECISIONS HAVE IMPACTED PATIENT CARE

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING THE BANKRUPTCY OF STEWARD HEALTH CARE, FOCUSING ON HOW MANAGEMENT DECISIONS HAVE IMPACTED PATIENT CARE

SEPTEMBER 12, 2024

Printed for the use of the Committee on Health, Education, Labor, and Pensions

Available via the World Wide Web: *http://www.govinfo.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

57–254 PDF WASHINGTON : 2025

C O N T E N T S

STATEMENTS

THURSDAY, SEPTEMBER 12, 2024

EXAMINING THE BANKRUPTCY OF STEWARD HEALTH CARE: HOW MANAGEMENT DECISIONS HAVE IMPACTED PATIENT CARE

Thursday, September 12, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:01 a.m., in room 562, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Hickenlooper, Markey, Cassidy, Collins, Braun, Romney, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Committee on Health, Education, Labor, and Pensions will come to order. It's very significant here in America today, we have a healthcare system, which in my view going to say the healthcare system is broken, but it's currently not the only thing that's broken. We have a healthcare system that is broken, dysfunctional, and cruel. Too often it is a system that is designed not to make patients well, but to make healthcare executives and stockholders extraordinarily wealthy.

There cannot be a clearer example of that than private equity billionaires on Wall Street who are making billions by purchasing hospitals throughout our Country, stripping all of their assets, and loading them up with debt that these hospitals could never pay back. Perhaps more than anyone else in America, Ralph de la Torre, the CEO of Steward Healthcare, is the poster child for this outrageous type of corporate greed that is permeating our for-profit healthcare system.

Working in partnership with a private equity firm, Cerberus, Dr. de la Torre became obscenely wealthy by loading up hospitals from Massachusetts to Arizona with billions of dollars in debt and selling the land underneath these hospitals to real estate executives at Medical Properties Trust who charged unsustainably high rents. As a result of Dr. de la Torre's elaborate financial scheme, Steward Healthcare and the more than 30 hospitals it owns in eight states, declared bankruptcy with some $9 billion in debt.

But let's be clear, Steward's severe financial problems did not happen overnight. They have been going on for more than a dec-

ade. It has been estimated that at least 15 patients at hospitals owned by Steward died as a result of a lack of medical equipment or staffing shortages, and that at least 2000 other patients were put in serious risk according to Federal regulators. Since 2019, Federal inspectors have cited Steward-owned hospitals over 30 times for putting patients in "immediate jeopardy" meaning the patients died, were put at grave risk, or were injured.

In 2014, Steward shut down the Quincy Medical Center, Massachusetts, with the exception of its emergency room, which it shut down 6 years later. Today, Quincy is the largest city in Massachusetts without an emergency room. In 2018, Steward shut down the Northside Regional Medical Center in Youngstown, Ohio, closing the only labor and delivery unit in that city for pregnant women and their babies, and laying off 468 healthcare workers in the process.

Last year, Steward shut down the Texas Vista Medical Center, the main healthcare option for San Antonio's south side after it missed over $650,000 in payments to medical suppliers leaving the hospital with a severe shortage of respiratory masks among many other things. Last month, state regulators required Steward to shut down St. Luke's Behavioral Center in Phoenix, Arizona after they found that it had been without air conditioning in Phoenix, as temperatures soared past 100 degrees, putting more than 70 patients at risk of heat exposure.

Steward has also shut down pediatric wards in Massachusetts, Louisiana, closed neonatal units in Florida and Texas, and eliminated maternity services at a hospital in Florida. We know that Steward has gone bankrupt. We know that several of its hospitals have already been forced to close their doors because they ran out of money.

But the question that is interesting to me is, in the midst of all of that, how is the main person behind all of these efforts, Dr. de la Torre, how's he doing financially? While hospitals shut down, while patients go without care, while healthcare workers lose their jobs, how has Dr. de la Torre been doing in terms of his own financial well-being? And the answer is that he has been doing phenomenally well.

While Steward was busy shutting down hospitals, the companies he owned received $250 million in compensation over a 4-year period. Let me repeat. He personally received hundreds of millions of dollars, some of which, remember, hospitals shut down, patients without care, workers being laid off, and some of that money he used to purchase this $40 million yacht.

While Steward Hospitals were severely understaffed, patients were not getting the care they desperately needed, Dr. de la Torre was able to afford this $15 million custom made luxury fishing boat. $15 million fishing boat while patients were dying. While Steward-owned hospitals cannot afford to pay for life saving medical supplies, it had enough money to purchase a $62 million private jet, and incredibly, a $33 million backup jet that Dr. de la Torre and his family used for non-business trips throughout the world.

While Steward's hospitals were laying off hundreds of workers, de la Torre made a $10 million charitable contribution to an exclusive prep school in Dallas that was fully paid for by Steward Healthcare, not his own personal funds. How many of Steward's hospitals could have been prevented from closing down? How many lives could have been saved? How many healthcare workers would still have their jobs today if Dr. de la Torre spent $160 million on high quality healthcare at the hospitals he managed, instead of a yacht, two private jets, a luxury fishing boat, and a huge contribution to a wealthy prep school.

Today, we will be hearing from nurses in Massachusetts and from public officials in Louisiana who have firsthand knowledge of the harm Steward has caused the patients, the healthcare workers, and the communities in which they live. I look forward to hearing from these panelists very soon. As the Chairman of this Committee, I look forward to working with Ranking Member Cassidy, and I want to thank him and his staff for their cooperation on this effort.

Senator Markey, I want to thank Senator Markey for his leadership. He is from Massachusetts. They have been very hard hit by Steward. And I hope that we will be working together every Senator, Democrat and Republican, to hold Dr. de la Torre accountable for his financial mismanagement and his greed.

But let me conclude by saying this. Dr. de la Torre did not act alone. Who else besides de la Torre benefited financially as a result of Steward's bankruptcy? Cerberus, the private equity firm he partnered with, made an estimated $800 million profit from its investments in Steward Healthcare. From 2017 through 2021, the CEO of Medical Properties Trust received about 70 million in bonuses, stock, awards, and salary. How much of that compensation came as a result of its financial arrangements with Steward?

The collapse of Steward Healthcare is just one extreme example of the damaging role in my view, that private equity is having on our healthcare system. Private equity firms have bought, bought up hundreds of hospitals, thousands of nursing homes, and tens of thousands of medical practices, saddling them up with unsustainable debt and stripping their assets to make huge profits for their executives and their investors.

Study after study has shown that on average, when a private equity firm takes over a hospital, a nursing home, or another medical provider, the price of healthcare goes up, the quality goes down, and healthcare workers are asked to do much more with fewer and fewer staff. The issue of private equity and healthcare is an issue this Committee must look into. We cannot allow wealthy private equity executives to treat our healthcare system as their own personal piggy bank.

Healthcare in America, in my view, must be a human right for every man, woman, and child in this country, and not simply an opportunity for billionaire investors to make huge profits.

Senator Cassidy, I want to thank you for your hard work on this, and you are recognized for an opening statement.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Senator Sanders.

For months this Committee has engaged in a bipartisan investigation into the bankruptcy of the Steward Healthcare and the impact on the delivery of its care at its hospitals. And I would add therefore, on the impact of the healthcare of the patients those hospitals served. It was quickly evident that breaking down the management decisions of Chief Executive Officer Dr. Ralph de la Torre is essential to understand Steward's financial problems.

Steward's bankruptcy has nationwide implications impacting more than 30 hospitals across eight states, including Glenwood Regional Medical Center in West Monroe, Louisiana. According to a report from the Centers for Medicare and Medicaid Services, a physician at Glenwood told a Louisiana State Inspector, "the hospital was performing Third World medicine."

Because of management decisions resulting in limited resources at Glenwood, the state had to force the hospital to operate at one-third capacity. One patient died waiting for a transfer to another hospital, because Glenwood lacked resources to treat. Glenwood is also the largest employer in West Monroe and West Ouachita Parish, at one point employing 9 percent of the community.

Now, hospitals like Glenwood are essential to the both physical and financial health of the communities they serve. We need to keep this from happening again. That means we need answers, and it seems the principle to give that answer is Dr. Ralph de la Torre, and this is what our bipartisan work has been about; answers for our constituents, answers to inform legislative solutions.

Unfortunately, Dr. de la Torre has refused to testify voluntarily. As a result, the Committee issued a subpoena in July. Up until September the 4th, Dr. de la Torre's lawyers indicated he intended to comply with the subpoena and to testify. However, 8 days before the hearing, Dr. de la Torre informed the Committee that he would not comply with the subpoena. We responded to Dr. de la Torre explaining why his objections to the Committee's subpoena have no merit and directed him to comply.

Now a witness cannot disregard and evade a duly authorized subpoena. Therefore, today the Chairman and I will be asking the Committee to report a resolution to authorize civil enforcement and criminal contempt proceedings against Dr. de la Torre, requiring compliance with the subpoena. I thank the Chairman for working with me on this critically important issue. I believe our actions today are a testament to what bipartisanship can accomplish on behalf of Americans, on behalf of patients. Thank you.

The CHAIR. Thank you, Senator Cassidy. And again, I want to thank you and your staff for their bipartisan efforts. As Senator Cassidy mentioned, our first witness is Dr. de la Torre, but as I think everybody can see, Dr. de la Torre is not here. He was subpoenaed to testify at 10 a.m. this morning. On September 4th, 2024, counsel for Dr. de la Torre sent a letter to the Committee, objecting to the compelled testimony and declining to comply with the subpoena. The next day, the Committee overruled these objec-

tions in their entirety and informed his attorneys that we expected to see Dr. de la Torre today.

Dr. de la Torre is not present in the room at this time, so I now call up our second panel of witnesses. Panel, if you would come to the dais, we would appreciate it.

[Pause.]

The CHAIR. All right. Let me thank all of our witnesses. We have four excellent witnesses from Massachusetts, Louisiana, and we thank them all for being here. Senator Markey has played a very important role in driving this investigation and has had a huge impact on communities throughout Massachusetts. So Senator Markey, I'd appreciate it very much if you can introduce our first two witnesses.

Senator MARKEY. Thank you, Mr. Chairman, very much, and thanks to you and Ranking Member Cassidy for your leadership on this issue.

Again, I continue to be grateful for partnering with the Subcommittee hearing that we had in April up in Boston to hold Steward Health accountable. Greed thrives in the dark, and these witnesses are bringing this story into the light.

Our first witness is Ms. Ellen MacInnis. Thank you for being here today. Ms. MacInnis serves on the Massachusetts Nurses Association Board of Directors. She has worked as a nurse for 35 years, including over 25 years at St. Elizabeth's Medical Center, a Steward-owned hospital. Ms. MacInnis worked in the coronary care unit, in the medical intensive care unit, and for 20 years in the emergency department. So we thank you Ms. MacInnis for your testimony. And we very much appreciate your leadership on this issue right from the very beginning.

The CHAIR. Let's introduce the other witness as well, and then we'll introduce all the witnesses and then we'll hear the testimony.

Senator MARKEY. The next witness is Mrs. Audra Sprague. Thank you for being here. Mrs. Sprague served as the co-chair of the Massachusetts Nurses Association at the Nashoba Valley Medical Center since 2015. She has also served as a member of the Massachusetts Board of Registration in nursing since 2021. Mrs. Sprague worked at the Nashoba Valley Medical Center in the emergency department for 17 years. She, alongside almost 500 healthcare workers and administrators, lost their jobs late last month when the bankruptcy court approved Nashoba Valley's closure due to Dr. de la Torre's financial mismanagement of Steward.

We thank you for being here. We thank all the hardworking healthcare workers like you and Ms. MacInnis who are fighting for patients, not just in Massachusetts, but all across our Country. You continued to save lives even as the resources were being drained out of your hospital. Thank you.

The CHAIR. Senator Cassidy, do you want to introduce the panelists from Louisiana?

Senator CASSIDY. Please. Although they're not sitting in that order, I'm going to ask Mayor Mitchell to go first. So I'll introduce her first. Staci Mitchell is the mayor of West Monroe, Louisiana, has held this role since 2018. Mayor Mitchell has served her com-

munity for many years previously as an alderman for West Monroe and owning a successful business for 20 years. She also serves as a board member of Glenwood, and her role on that board gives us insight into the day-to-day operations of Glenwood and their challenges.

She holds a Bachelor's of Science in Agricultural Economics from Louisiana State University. And Mayor Mitchell, thank you for being here. And by the way, I trust West Monroe is doing well with the hurricane?

Ms. MITCHELL. Yes.

Senator CASSIDY. Next, I will introduce State Representative Michael Echols. And Michael is a state representative first elected in 2019, representing District 14, which includes Monroe and Ouachita Parish. Representative Echols serves on a number of important committees, including the Health and Welfare Committee, where he has spent significant time investigating Glenwood Regional Medical Center and their mismanagement. And he'll bring to this table the insights learned from the Louisiana Legislative Sessions. He holds a Bachelor of Science in Accounting from the University of Louisiana, Monroe, and a MBA from the University of Louisiana, Monroe.

Thank you both for being here.

The CHAIR. Thank you, Senator Cassidy.

Ms. MacInnis, the floor is yours, and thank you very much for being with us today.

STATEMENT OF ELLEN MACINNIS, R.N., NURSE AT ST. ELIZABETH'S MEDICAL CENTER, BOSTON, MA

Ms. MACINNIS. Thank you, Senator.

The CHAIR. Just make sure the mic is on and talk into it and hold it close to your mouth for that, please. A little bit closer.

Ms. MACINNIS. Okay. Thank you, Senator. Thank you. Thank you, Senator Sanders, and Members of this Committee. My name's Ellen MacInnis. I'm a nurse at St. Elizabeth's Medical Center in Boston. I've been there 26 years. For the first 12 years I worked at St. Elizabeth's, we were operated by the Archdiocese of Boston, and then Cerberus Capital came along, Steward came along, and it's been downhill since then.

We have 2,800 Massachusetts Nurses Association nurses and healthcare professionals working at Steward Hospitals. I'm proud and honored to be representing them today. We hope that we can provide a unique perspective on this issue, because we are the front-line providers, we provide more than 90 percent of the care delivered at Steward Hospitals.

The corporatization and commodification of healthcare is the guiding ethos of Steward. It's the one and only priority, and it has led to horrific suffering and harm to our patients, the people who take care of our patients, and our communities. The immediate and most debilitating impact of the ownership of Steward was the Steward's tendency to understaff units whenever and wherever they can. I spent 20 years working in the emergency department at St. Elizabeth's, and I can tell you we always struggled to have

enough staff, enough equipment, enough supplies to keep our patients safe.

Probably one of the biggest impacts is after a patient is admitted to the hospital, they end up sitting in the emergency department for hours to sometimes a couple of days, because the units where they should be admitted and safely cared for are not staffed. This chronic understaffing has resulted in preventable harm and even death. *The Boston Globe* just ran a front-page expose, highlighting some of the tragic consequences at Steward Hospitals. This included two patients at Holy Family Hospital in Methuen who died in the emergency department because they weren't immediately assessed and they weren't monitored, and that relates directly to severe understaffing of that department.

At Good Samaritan, two patients died after spending hours in a significantly understaffed emergency department. One 81-year-old gentleman came in for chemotherapy for his pancreatic cancer, and by the time staff got to him, he was dead. There were 95 patients in that emergency department on that shift, and only 11 nurses. It is absurd to think that 11 nurses can care for that number of patients. Another Steward hospital, sadly enough, a 28-year-old gentleman came in. He was in an acute mental health crisis. He was placed in restraints for his own safety, and there was nobody available to closely monitor him, which is what statute provides for. And when he went into distress, nobody was there to rescue him and he's dead.

All of these were preventable. We also have seen Steward fail to provide the supplies and the equipment that we need. Either the supplies don't come through the front door because we're on a credit hold and nobody will bring them to us. Also, our equipment it's not properly maintained. We have IV pumps and computers with battery lives of seven to 10 seconds, because the maintenance just hasn't been done.

During my time in the emergency department, I worked nights, there were nights that we didn't have any Similac or Pedialyte or even diapers. I can think of two separate occasions where staff went out in the middle of the night to a 24-hour store to get those supplies. Also, we frequently didn't have food kitchens locked up. And I personally have given my dinner, my meals to patients, and staff has chipped in and sent out and had food brought in for patients.

Sadly enough, sometimes babies die, newborn babies die, and the practice is to place the baby's remains in a bereavement box and take it to the morgue. Steward didn't pay the vendor, and there weren't any bereavement boxes and nurses were forced to put babies' remains in cardboard shipping boxes. These nurses put their own money together and went to Amazon and bought the bereavement boxes.

Gosh, there's so much more to say. Probably the most tragic and what finally blew the lid off all this, was the death of a 39-year-old woman who came to the hospital, had an absolutely normal childbirth, was bleeding. She may have been saved by a device known as an embolism coil. There weren't any in the hospital.

There hadn't been any in the hospital for weeks. They had been repossessed by the vendor. She died.

Steward has also caused the closure of Quincy Medical Center. I grew up in Quincy. This was very close, very close to my heart. And now Nashoba and Carney Hospital. Carney Hospital sees more than 30,000 patients a year. Boston AMS takes 6,000 patients a year to Carney Hospital. Where are they going to go? We don't have the capacity in Boston for this. I know we have a lot of hospitals, we also have a lot of patients.

Just to be clear, we need not to let this happen again. And thank you for coming together, and it's my sincerest hope that you can put an end to this. Thank you.

[The prepared statement of Ms. MacInnis follows.]

PREPARED STATEMENT OF ELLEN MACINNIS

Thank you, Senator Sanders and to the other Members of this Committee for the invitation to testify today.

My name is Ellen MacInnis, a former Steward nurse at St. Elizabeth's Medical Center in Boston, and a member of the Massachusetts Nurses Association Board of Directors. I have the honor and privilege of representing more than 25,000 RNs and health professionals working in facilities across the Commonwealth from Cape Cod to the Berkshires. This includes more than 2,800 RNs and health professionals working in eight of the nine Steward owned hospitals in Massachusetts. In coming here today I hope to provide a unique perspective on the issue, as we are the front-line providers who deliver 90 percent of the clinical care patients receive at these facilities. We also can provide a unique historical perspective as our members have worked at nearly every facility owned or operated by for-profit entities—be they private equity firms, or traditional for-profit providers accountable to shareholders on Wall Street since these firms first entered our state back in the 1990's.

As a nurse who has given decades of service at St. Elizabeth's Medical Center, I had worked at the facility when for years it was a not for profit facility run by the Archdiocese of Boston, and for the last 14 years following the purchase of our hospital by Cerberus Capital Management, and soon to be named Steward Healthcare.

From the perspective of nurses and health professionals on the front lines of the Steward system the impact on our patients and our communities was the same—the corporatization and commodification of health care which is the guiding ethos of Steward and other such providers has left a trail of broken promises made to these communities and the state agencies responsible for the regulation of these providers, and more importantly, to the degradation of patient care leading to an unprecedented level of suffering for the patients and families who depend on us for their health and safety.

The immediate and most debilitating aspect of ownership by Steward for those of us charged with providing care to patients was the chronic lack of staff needed to deliver appropriate timely care to our patients. Having spent 20 years working a busy, urban emergency department, I can tell you we were always struggling to provide life-saving emergency care in a department that was often overwhelmed with patients, with patients boarding in hallways going without care, including critically ill patients waiting to be admitted to our intensive care units, but these patients couldn't be moved to those units due to the lack of needed staff. Every day was a constant struggle to convince Steward to add the staff we needed to meet the needs of patients and every day, little or nothing was done to address our concerns. And it was the patients who suffered the consequences, in delays in receiving needed medications and treatments, in care left undone, with patient suffering preventable falls and in too many cases, severe harm and even deaths.

The *Boston Globe* just ran a frontpage expose highlighting some of the tragic consequences of these staffing shortages at Steward Hospitals. This included two patients at Steward owned Holy Family Hospital in Methuen Mass who died in the hospital's emergency department, one a 38 year-old and another 81 year-old male who both died from being undiagnosed and going without proper monitoring in the ED due to the lack of staff on hand to provide that monitoring and assessment.

At Steward Good Samaritan Hospital in Brockton, two other patients died after spending hours in an emergency department significantly understaffed. In one instance, a patient admitted for chemo therapy for pancreatic cancer died alone on a stretcher in a hallway, after spending hours waiting to be seen at a time when the ED was staffed with just 11 nurses caring for 95 patients. No ED nurse should be expected to or can safely care for eight or nine patients at a time, but at this hospital, and other Steward hospitals, this was a regular occurrence.

At another Steward Hospital, a patient experiencing an acute mental health crisis who was placed in restraints, who was supposed to be receiving one to one monitoring to ensure his safety, ended up dying because the hospital was unable to provide that level of monitoring due to the lack of staff.

These were not isolated instances, and I emphasize, all of them were totally preventable.

The other common issue for Steward which severely compromised staff's ability to provide the care our patients deserve was the lack of supplies and equipment needed for the care of patients. This ran the gambit from the lack of basic necessities to life saving equipment.

During my time in the emergency department, there were many nights when we didn't have baby formula on hand for a mother or clean onesies for an infant who had soiled themselves while coming to us for care. Or often at night, there were no food stuffs to feed a hungry diabetic or patients who were waiting for hours to be seen, forcing us to send one of our colleagues out to purchase these basic necessities.

We had nurses going from floor to floor searching for needed medical supplies, such as IV tubing, bandages, linens, you name it, all of it not available because the vendors who supplied those materials hadn't been paid by Steward for months, and were now placed on vendor hold waiting for that overdue payment.

A more egregious and appalling example at my hospital was the failure of Steward to ensure a supply of bereavement boxes, which are the cases used to carry the remains of deceased newborns to the morgue. Instead, staff were expected to transport these remains in banker's and shipping boxes. To compensate for this indignity it was left to our own nurses to go on line and purchase appropriate containers on Amazon.

The most tragic example, also reported in the *Boston Globe*, was the tragic and preventable death of a 39 year-old mother simply because the embolism coil that would have saved her life had been repossessed by another unpaid vender.

In addition to the lack of supplies, we watched Steward totally neglect the infrastructure of our facilities, allowing equipment to go unrepaired, and to see once proud institutions deteriorate before our eyes. At one of our facilities, a suicidal patient leaped to his death from a window that was supposed to be locked shut, but was pried open because of its being in severe disrepair.

At my hospital, several floors went 36 hours without electricity due to faulty wiring and electrical issues, forcing nurses to run long extension chords to be able to run monitors and other equipment needed to monitor and treat patients.

Let us be clear, none of this is acceptable on any level at any time. All of it was preventable. Those responsible for this needless suffering deserve to be held accountable for both their actions, and their inaction, which is why we are here speaking to you today, in the hope that you will find a way to hold Steward and Ralph de la Torre accountable for what they have done to our patients and our communities. And beyond that, we hope you can use this process and your power to prevent such harm from being caused by other providers who choose to place their desire for profit margins over their mission of caring for the most vulnerable among us.

Finally, we think it is important to point out that it is not just Steward, private equity or other types of for-profit providers that need to be held accountable. Our state and Federal agencies that are charged with regulating and ensuring the safety of our health care providers and facilities must also be held accountable for doing their part in protecting the public. We want to make clear that our nurses and our association went to great lengths over a period of years to document and report the behavior, practices and outcomes at our facilities to all levels of state and Federal Government, and it wasn't until the bankruptcy filing was announced that there was any real or meaningful effort to address our concerns about Steward. We would also point out that while Steward is definitely a bad player in the health care market, they are by no means alone.

It is our hope that this crisis can serve as a wake up call to all levels of government and to the public that the danger to our public health from the influence of the profit motive into health care is significant and that we all must do our part

to change the system to protect our most valuable resource—the health and well being of all who live in this great nation.

[SUMMARY STATEMENT OF ELLEN MACINNIS]

My name is Ellen MacInnis, a 26-year nurse at Steward St. Elizabeth's Medical Center in Boston, and a member of the Massachusetts Nurses Association Board of Directors. I have the honor and privilege of representing more than 2,800 RNs and health professionals working in eight of the nine Steward owned hospitals in Massachusetts.

My testimony will provide a unique perspective on the issue, as we are the front-line providers who deliver 90 percent of the clinical care patients receive at these facilities.

From the perspective of nurses and health professionals on the front lines of the Steward system the impact on our patients and our communities was the same—the corporatization and commodification of health care which is the guiding ethos of Steward and other such providers has left a trail of broken promises made to these communities and the state agencies responsible for the regulation of these providers, and more importantly, to the degradation of patient care leading to an unprecedented level of suffering for the patients and families who depend on us for their health and safety.

The testimony details how Steward's failure to provide appropriate staffing at their facilities led to a host of patient injuries, including a number of preventable patient deaths at five different facilities.

It will highlight the impact on patient care of Steward's failure to pay its vendors, resulting in nurses and other staff being unable to find basic supplies, as well as lifesaving equipment, in two cases, leading to patient deaths.

Finally, it will call for accountability for Steward and its executives for the harm they have caused for the hundreds of thousands of patients and communities it had a mission to serve, while also calling for future accountability for all health care providers who place a priority of profits over the delivery of patient care.

The CHAIR. Thank you very much.

Ms. Sprague.

By the way, if you need more than 5 minutes, that's fine. Take seven, 8 minutes if that's what you guys need.

STATEMENT OF AUDRA SPRAGUE, R.N., FORMER NURSE AT NASHOBA VALLEY MEDICAL CENTER, LUNENBURG, MA

Ms. SPRAGUE. Thank you. Thank you, Senator Sanders, and the Members of this Committee for bringing this to the forefront. My name is Audra Sprague. I'm a registered nurse. I worked at Nashoba Valley Medical Center for 17 years.

Steward Healthcare systematically extracted every possible dollar that they could get out of our hospital until it led to its closure 12 days ago on August 31st, 2024. Since Steward's ownership, I have witnessed personally myself some firsthand devastating effects of the company's practices of reducing overhead to financially benefit their stakeholders and their CEO, with no regards for the patients and the impact on the patients and their care and the family and our staff.

Under Steward, essential resources began to dwindle repairs that once would've been done immediately, were put off and delayed, sometimes they weren't addressed at all. For example, if you have a critically ill patient, you need IV access as quickly as you can to give them fluids and medications. And if you can't get it within a very reasonable small amount of time, you use what's a mechanical

drill called an IO to go through the bone, into the bone marrow. But it's mechanically powered, so it goes faster, and less trauma and pain for the patient.

Our drill battery died and it's a closed system, so the vendor hadn't been paid. We couldn't get one from that vendor, so they had to source it from another place. We ended up getting this subpar—it was like a Fisher Price toy. It felt like it was this mechanical, like you had to hand pump it to get this big bore needle to go through the bone into a patient. Technically it worked, but it was ridiculously poor quality. And it's just a perfect example of Steward only cared about the money and didn't care about what was happening to the patients.

As beds broke, they weren't repaired. So, when our census would increase, we would have to rent beds for a long time. Then all of a sudden, we couldn't even rent the beds because we were on credit holds. So, we were forced to transfer patients to other facilities because we didn't have the physical bed for them to lay down in an actual hospital bed.

Our hospital is licensed for 57 medical beds, plus 20 geriatric psychiatric beds. Of the 57 medical beds, by the time we closed, we probably had around 18 to 20 working beds. So, working under these conditions became overwhelming for everybody, nurses, doctors, anybody in the hospital at every different level. Due to the chronic understaffing and lack of supplies, it became our burden to try and make up for the financial, like strain that we were under. So, we would keep that same level of care for the patient whenever we could by hiding the chaos that was going on outside and hiding all of the things that had to be done to get the care for that patient. And it was exhausting.

It's already a very demanding job, and they made it almost impossible to do. On July 5th, 2023, I had to bring my then 18-year-old son into the ER at Nashoba. I knew he would be cared for well, I trusted every single person in there. But Steward had made it so there was such low staffing and didn't care about the constant pleas for, we needed more staffing on overnights. He was diagnosed with new onset type 1 diabetes and was in diabetic ketoacidosis, which is a life-threatening complication of type 1 diabetes. He was admitted as an ICU patient into the hospital.

But there was no ICU beds. There was beds, there just wasn't nurses because they hadn't staffed it. So, he had to stay in the ER that entire night. That night, there were two nurses staffed in the ER, despite us constantly saying we needed more, and there were 18 patients in the ER that night. So, no way in the world could two nurses, no matter how fast they were, how hard they worked, no matter what, could care for 18 patients.

In the state of Massachusetts, if you're an ICU patient, you should have one-to-one nursing, at times one-to-two, but at a minimum, it should be one-to-one on an insulin drip. The nurses there could not meet all the needs. They couldn't get to all the patients. So, I myself had to take care of my own child, titrating the drip, making sure that he was getting what he needs on the critical and emergent needs that he had being in diabetic ketoacidosis.

The lack of overnight staffing in that ER has been ongoing. It was a known patient safety issue. Despite our local administration, our local hospital, CEO, CNO, acknowledging it and wanting to support it and wanting to fill it, corporate no matter what, they would just say no. In our negotiations that had just ended a few months before on the new contract, we wanted a third nurse on nights. We asked for it over and over, and the corporate negotiators were like, "Nope, you don't need it, you can't have it," despite everybody saying it was needed?

But to ensure that my son received the critical time sensitive care he needed, I had to be his nurse that night and not his mother. And he deserved to have both. He deserved to have a one-on-one nurse and a mother there to support him. And I wasn't able to do that because I had to focus on his nursing care and make sure that he was Okay.

Steward's abrupt closure of Nashoba with barely 30 days' notice has left our region without critical healthcare services. Our transport times for ambulances have doubled or tripled, our local EMS systems are in no way going to able to consistently meet these needs, and there was no time to buildup. They just said, "Nope, we're closing. 30 days, that's it." And we have no public transportation. There's not even Ride or, Lyft, Uber, anything near us. Maybe every now and then you can get one.

But the closure has resulted in longer waiting times for emergency care, for essential screening tests at other hospitals like mammograms, colonoscopies, all of those things now, other hospitals are going to have to add all of our patients that were getting those services at Nashoba into these hospitals, that they were already overwhelmed, especially in the emergency departments at the two closest hospitals to us.

Moreover, Nashoba's closure has left the primary care physicians that are still in place, with no place to send them for diagnostic testing like X-rays, CTs, ultrasounds, MRIs. They have to go drive a half hour to get, any of those services, if they can get in for them.

It's just, Steward has a pathological lack of concern for anyone but themselves. They do whatever is good for them. They repeatedly misrepresented or outright falsified information to the state regulators intending to downplay the impact of the closure. For instance, DPH inquired about the closure plan, what the transportation options would be in our area after the closure so patients could get back and forth to appointments. In the response to DPH's question, Steward cited, a company called Here to There Transport, and said that they are providing 24/7 transportation. The way it was worded was completely meant to imply that this was going to solve the situation. Here to There Transport is one woman named Joanne.

[Laughter.]

Ms. SPRAGUE. She is lovely, like, don't get me wrong, but she used to provide us with vouchers for patients that would need a cab ride home or some sort of transportation home, but she mainly does airport transport, so she needs to sleep. And she's not 24/7. She's one person. And then she even stopped doing that because Steward wouldn't pay them. So, she would provide the transport—

and so it's definitely not a solution for our entire community's, healthcare needs.

They portrayed us as a failing hospital with declining census to justify closure in the state. But the narrative conceals that the corporative executives have systematically deprived our hospital of essential resources for years, including not giving us consistent gastroenterology, general surgery, urologists, anesthesiologists. And as a result, Nashoba was forced to transfer our patients for care that we could no longer provide.

The Steward's greed has put lives at risks and their action is going to kill people. And it's left a complete hole in our community that despite the warnings and pleas, nothing's been done to stop them. They have unchecked greed across the board. And it's not just a business failure, it's a human tragedy waiting to happen in our region. Thank you.

[The prepared statement of Ms. Sprague follows.]

PREPARED STATEMENT OF AUDRA SPRAGUE

My name is Audra Sprague, and I was a registered nurse in the ER at Nashoba Valley Medical Center for 17 years. Steward Health Care systematically extracted every possible dollar from our facility, leading directly to its closure 12 days ago on August 31, 2024. Nashoba Valley Medical Center was vital to the health of residents in our region.

Since Steward took ownership, I've witnessed and experienced firsthand the devastating effects of the company's practices of reducing overhead to financially benefit the stakeholders. Under Steward, essential resources began to dwindle. Repairs that once would have been immediate were significantly delayed, if addressed at all. For example, when we were unable to gain IV access quickly on a critically ill patient, best practice is to use a mechanically powered drill that inserts a needle into bone marrow, allowing us to administer medications and fluids. When the battery died on our drill, Steward failed to pay the vendor, leaving us without a functioning drill. They eventually replaced it with a subpar hand-pump manual drill, which was technically compliant but woefully inadequate for the needs of critically ill patients.

As beds broke, they were not repaired. When the census increased, we would rent beds, until the vendors put us on "credit hold" because bills were not paid. We were forced to transfer patients to other hospitals for care because we didn't have a physical bed to put them in. Our hospital was licensed for 57 medical beds, but at the time of our closure, we had approximately 18 working medical beds.

Working under these conditions was overwhelming. Basic nursing tasks were challenging due to chronic understaffing and lack of supplies. The nurses and doctors shouldered the burden of maintaining the standard of patient care. We became very adept at doing more with less, but it made an already demanding job nearly impossible.

On July 5, 2023, I brought my then 18-year-old son to the ER at Nashoba. He was diagnosed with new-onset Type 1 diabetes and was in diabetic ketoacidosis, which is a life-threatening complication. He was admitted as an ICU patient, but due to a lack of staffing in the ICU, my son was forced to stay in the ER as an ICU boarder. That night, there were 18 patients in the ER. In Massachusetts, an ICU patient on an insulin drip, by law, should have 1:1 nursing care. His nurse in the ER had 8 other patients to care for. I had to provide his care myself, as the two ER nurses could not possibly meet the critical and emergent needs of all 18 patients. The lack of overnight nursing staff in the ER was an ongoing patient safety issue. Despite local administration's support for more nursing staff on the overnight shift, repeated requests were dismissed during contract negotiations by Steward's corporate executives. To ensure my son received the critical, time-sensitive care he needed, I had to act as his nurse that night instead of his mother. He deserved to have his mother and a 1:1 nurse. Steward's abrupt closure of Nashoba, with barely 30 days notice, has left our region without critical healthcare services.

Transport times have doubled or tripled one way. Our local EMS systems will not be able to consistently meet the demand, which is made worse by the lack of public transportation. The closure has resulted in longer wait times for emergency care

and essential screening tests, such as mammograms and colonoscopies, at hospitals farther away. Moreover, with Nashoba's closure, local primary care physicians and specialists have lost the ability to obtain diagnostic services like MRIs, CTs, ultrasounds, and simple X-rays. Steward has shown a pathological lack of concern for anyone but themselves.

Steward repeatedly misrepresented or outright falsified information to state regulators, intending to downplay the closure's impact. For instance, when the DPH inquired about transportation options for residents after the hospital's closure, Steward cited a company called "Here to There" Transport LLC that supposedly provides 24/7 transportation. This was presented as if it solved the problem of no public transportation or ride-sharing services in the region. In reality, "Here to There" transport is one woman named Joanne who primarily provides airport transfers—not the solution to our community's healthcare access issues.

Steward portrayed Nashoba as a failing hospital with a declining patient census to justify the closure to the state. However, this narrative conceals the fact that Steward's corporate executives systematically deprived the hospital of essential resources for years, including specialty physicians such as gastroenterologists, general surgeons, urologists, and anesthesiologists. As a result, Nashoba was forced to transfer patients to other hospitals, such as St. Elizabeth's, for care that could no longer be provided locally. What appeared to be a hospital in decline was, in fact, the result of Steward's calculated neglect.

The closure was not because the hospital was failing; it was Steward's failure to support it. Steward's greed is putting lives at risk, and their actions—or lack thereof—will kill people. They have systematically dismantled healthcare in our community, leaving us without the resources to save lives in critical moments. Despite repeated warnings and desperate pleas from healthcare professionals, no one has stepped in to stop them. Steward's unchecked greed has created a healthcare crisis, and if nothing is done, people will die as a result. This is not just a business failure—it's a human tragedy waiting to happen.

[SUMMARY STATEMENT OF AUDRA SPRAGUE]

My name is Audra Sprague, I am a registered nurse with 17 years of service at Nashoba Valley Medical Center, I will give testimony regarding what it was like to work in a Steward-owned hospital and the impact the hospital's closure had on our community. My testimony will attribute the closure to the mismanagement and profit-driven strategies of Steward Health Care, which acquired the hospital in 2011. Under Steward's ownership, the hospital's resources were systematically drained.

Steward's cost-cutting measures limited staff's ability to provide care. Essential equipment was neglected or replaced with inadequate substitutes. Maintenance and repairs were postponed, resulting in insufficient medical facilities and increased pressure on the staff. This deterioration was compounded by chronic understaffing, which made basic tasks increasingly difficult and placed a heavy burden on staff.

My testimony will discuss a time when my 18-year-old son was admitted to the emergency department with a life-threatening condition but was forced to remain there due to a lack of available ICU beds. As a result, I had to provide care for my son due to inadequate staffing, instead of being able to provide him support as his mother.

The hospital's closure has had severe repercussions for the surrounding community. Patients now face extended transport times to receive care at distant hospitals, straining local EMS systems and further burdening already overwhelmed healthcare facilities. The loss of Nashoba Valley Medical Center also means that local primary care physicians and specialists have lost a crucial resource for diagnostic services.

My testimony will explain how Steward Health Care provided misleading information to state officials, downplaying the impact of the hospital's closure. The company's portrayal of Nashoba as a failing hospital with a declining patient census was misleading; in reality, the hospital's struggles were a result of Steward's deliberate neglect.

Steward Health Care's pursuit of profit over patient welfare led to the hospital's closure and created a healthcare crisis. The repeated and constant profit driven decisions continue to have life-threatening consequences for my community, creating a grave situation in many communities around the country, all led by corporate greed.

The CHAIR. Thank you very much, Ms. Sprague.

Representative Echols. Oh, I'm sorry. Ms. Mitchell.

STATEMENT OF MAYOR STACI ALBRITTON MITCHELL, WEST MONROE, LA

Ms. MITCHELL. Good morning, Chairman Sanders, Senator Cassidy, and the other Members of the HELP Committee. My name is Staci Albritton Mitchell. I'm the mayor of the city of West Monroe, Louisiana, and as Dr. Cassidy mentioned, I'm also a member of the Community Advisory Board for Glenwood Hospital. And I never expected to be here before in my life, testifying before Congress, but what my community has experienced over the last year, I think is worth your attention.

I appreciate this opportunity to testify on the impacts the Steward Health System has had on our city, West Monroe, as well as the northeast Louisiana region. The city of West Monroe is located in northeast Louisiana. We're home to about 13,000 residents, but our eight-parish region has almost 300,000 residents. West Monroe is the home of Glenwood Regional Medical Center, it is managed by Steward Healthcare. It serves as one of the primary health access points, not only for West Monroe, Ouachita Parish, the eight other parishes I mentioned, as well as it takes transfers from 26 rural hospitals.

During Steward's management, access to emergency care became greatly diminished and at times unavailable. This created a strain on the other healthcare facilities in our region. And when Glenwood was put into immediate jeopardy status in December 2023, patients seeking emergency room services had to be diverted to other facilities 10 to 20 minutes away on the other side of the Ouachita River from West Monroe. And there are reports of these individuals waiting hours upon hours and sometimes days to receive services.

Even with the Glenwood ER open, there kind of became a lack of overall confidence in the care that was provided at Glenwood. And some residents chose to seek services in hospitals even further away, creating, more stress on an already stressful situation and of course, more expense for, kind of an impoverished region. But this also overwhelmed the other hospitals.

While patient care is the priority, Glenwood is also an important economic driver. It is the largest employer in the city of West Monroe and West Ouachita Parish. And before Steward's reductions, there were over 1200 employees at Glenwood, and today there are approximately 750. I can't overstate to you what a closure of Glenwood would do to these employees and their families.

Those who work maintenance and janitorial and clerical type jobs will be affected the most. There's a shortage, of these jobs in our region, and the medical professionals would likely have to go somewhere else. They would have to relocate to find employment, which would also worsen the shortage of professionals and specialists that we have in our area. In addition to the effects on the direct employees, Steward has either not paid or they have delayed paying local vendors.

Last November, I was contacted by a local landscaper asking if there was anything that I could do to assist in getting paid. He had been, providing the services but had not been paid in several, several months. I said, "Send it over. Let me see what I can do if I can help." When I got the invoice, I was surprised it was for $72,000. And for a small business with a family and dependents and employees, that's a lot of money and could put them out of business.

Now I want to be clear that the caring employees of Glenwood, they have held that hospital together during challenging times. Their dedication, their commitment to their patients and to our community, is to be commended. And this situation, though, it continues to cause mental and physical stress on them because they don't know if they're going to have a job tomorrow or not, or what conditions they're going to have to work under.

In West Monroe, we welcome outside investment. We know that good healthcare is a must for a region to prosper and Steward's management has had a negative effect on our efforts to attract business residents and industry. It is imperative that when individuals or companies invest in critical infrastructure, such as healthcare, that they do so in a responsible manner, and they have their patients and the well-being of all in mind. And in Steward's case, there was a failure to uphold this responsibility. And you can see the ramifications easy in West Monroe and in these other communities that have Steward-managed hospitals.

I thank you for the opportunity to be here. I also hope that you will be able to do, something will come of this, because I want to ensure that nothing like this happens to another community. Thank you.

[The prepared statement of Ms. Mitchell follows.]

PREPARED STATEMENT OF STACI ALBRITTON MITCHELL

Good morning, Chairman Sanders, Ranking Member Cassidy, and Members of the Senate Health, Education, Labor, and Pensions Committee.

My name is Staci Albritton Mitchell, and I am the Mayor of the city of West Monroe, Louisiana. While I never expected to testify before Congress in my lifetime, I feel that what my community has experienced over the last year is worth your attention. I appreciate the opportunity to be here today to testify on the impacts the Steward Health System has had on the City and the greater region.

For background, the city of West Monroe is located in northeast Louisiana and has a population of 13,000. This region is home to almost 300,000 residents. West Monroe is the home of Glenwood Regional Medical Center, which is managed by Steward and serves as the primary health access point for the residents of West Monroe, as well as Ouachita parish and 8 other surrounding Parishes. Glenwood accepts transfers from 26 rural hospitals in Northeast Louisiana. Glenwood was originally established in the 1960's. It was purchased by Steward Health in 2017 and has been under Steward's management since then.

I mentioned before that Glenwood is a primary access point for almost 300,000 people, many of whom have been put at risk in the last year because of Steward's management. During Steward's management of Glenwood access to crucial emergency care became greatly diminished and at times unavailable, creating a strain on other healthcare facilities in the region. When Glenwood was put into "Immediate Jeopardy" status in December 2023 patients seeking emergency room services had to be diverted to facilities located across the river, up to 10 to 20 minutes further, such as Saint Francis Medical Center or Ochsner Hospital, quickly leading to severe overcrowding at these other facilities. There are reports of individuals having to wait hours and even days to receive services.

Further, even with the ER open, these self-inflicted service reductions led some people to a lack of overall trust in the community for the care provided by Glenwood. Some Northeast Louisiana residents are choosing to seek services further away, enduring increased travel and expenses in a rural, impoverished region, which further stresses other hospitals.

While patient care is the priority, Glenwood is also an important economic driver. Glenwood is the largest employer in the city of West Monroe and West Ouachita Parish. Before Steward's service reductions there were over 1200 employees at Glenwood. Today there are approximately 750 employees.

I can't overstate what a closure of Glenwood would do to these employees and their families. Those who work maintenance, janitorial and clerical type jobs will be affected the most because of the lack of those types of jobs in the region. The medical professionals would likely need to relocate to find new employment, which would worsen an already dire shortage of these professionals in the area.

In addition to the effects on its direct employees, Steward has either not paid or delayed paying local vendors. As an example, last November I was contacted by a local landscaping company asking for assistance dealing with Steward on an unpaid invoice. The business owner was contracted with Steward to provide landscaping services and had been faithfully fulfilling his duties under the contract. Steward, on the other hand, failed for several months to provide any payment for these services. I was provided the unfulfilled invoice for $72,000. While the invoice was eventually paid, a rural small business with employees and dependent families can be forced to shut down for an unpaid invoice of that size.

I want to be clear that the caring employees of Glenwood have held the hospital together under extremely challenging conditions. Glenwood employees should be commended for their dedication to their patients and our community. This situation continues to cause mental, emotional and physical stress on these employees not knowing if they are going to have a job tomorrow.

West Monroe welcomes and encourages outside investment into our community. Accessibility to good health care is imperative for a region to prosper. Steward's management of Glenwood is having a negative effect on our efforts to attract new business, industry and residents to our region.

It is imperative that when individuals or companies invest in critical infrastructure, such as health systems, that they do so in a responsible manner with the health and well-being of all who are dependent on services in mind. In Steward's case, there was a failure to uphold this responsibility, and the various ramifications of that failure are easily seen within West Monroe and the other communities across the Nation that were impacted by Steward hospitals. I want to ensure that other communities don't have to go through this.

Again, I appreciate the opportunity to participate in today's hearing and am happy to answer any questions you may have.

The CHAIR. Mayor Mitchell, thank you very much.

Representative Echols.

STATEMENT OF REP. MICHAEL CHARLES ECHOLS, LOUISIANA HOUSE OF REPRESENTATIVES, MONROE, LA

Mr. ECHOLS. Thank you, Senator Sanders, Senator Cassidy, and panel. Today is a very important step in holding those accountable in this healthcare delivery system that continue to rob from all of us across America. Only you at the Federal level can make this happen. I'm going to highlight some of the hearing that we had in Baton Rouge.

After a year and a half of hearing from local physicians, nurses, and other providers that there was a problem, we started to see service lines being cut for delivery in Northeast Louisiana from intensive services, urologic care, all the way down to basic MRI diagnostics. Physicians called me highly alarmed that they were unable to deliver quality care, which they're used to being able to give by having the resources.

After about 6 months of hearing many of these stories, as a legislator, I felt inclined on the Health and Welfare Committee, that we needed to have a hearing and have a broader discussion with the local management, which are essentially Steward hired executives that they brought in. On April the 9th, I had a hearing. Now this is after the facility had been placed in medical jeopardy numerous times, numerous conversations with our Louisiana Department of Health, at the time, Stephen Russo was the legal counsel there working as executive counsel in conjunction with all the other leadership at LDH. We summoned the interim president and CEO Jon Turton to a committee meeting along with community members, much like you've done from across America today.

In that hearing we heard impact from other regional hospitals on how they had to pick up the load when Steward and Glenwood were unable to keep up with the patient volume, they cut their numbers by two-thirds. They testified to the fact that it was tens of millions of dollars in additional costs that they were not able to recoup. They even did service lines for Glenwood. St. Francis Hospital, one of the regional hospitals, which up until the day of the hearing had not been paid for MRI services that they were helping out this other regional hospital.

LDH testified that they didn't have supplies on hand. And when they came in and put them under medical jeopardy all the way down to basic $1, $2 supplies, things that you need for surgical care, were not on hand and patients there ended up getting hurt because of that. Several members of staff told me about infections that happened with patients and patients dying because of the lack of those supplies.

All this led up to this hearing where when we deposed Mr. Turton, the interim CEO, he admitted on the record that Steward was solely responsible for not providing the financial resources that they needed to provide adequate care to that hospital. He also, on the record, noted that because of their mismanagement, they killed and maimed patients. When that interim leader, the Steward hired executive, admits that on the record, we have a substantial problem.

When I hear my colleagues from across America here to talk about these deficiencies in the healthcare system, it is glowingly clear to me that the executives of Steward Health Group are healthcare terrorists. They are killing our patients, they're killing our communities, and they need to be held accountable.

I think the problem is broader. Senator Sanders, you mentioned at the beginning of the hearing that there are other organizations involved. Medical Properties Trust coupled with Steward, have facilitated a Ponzi like scheme, that to me, has to be held accountable as well. Funneling billions of dollars through private equity into these healthcare delivery systems are creating criminal enterprises.

I'm hopeful that this Committee, after this subpoena of the CEO, who no-showed, can hold him accountable, put him in jail, because that's where he deserves to be for stealing this money from all of our communities. Glenwood and its employees and the people on the ground are terrific people. They've done everything in their

power to make sure that the patients get everything they can, but their hands have been just completely tied.

This has created a massive imbalance in our healthcare delivery system in northeast Louisiana. We're trying to keep the pieces together, but I do want to make sure, and after this panel is over, that organizations like Medical Properties Trust cannot continue to fund other bad actors who are going to come right after Steward, because this isn't the only game in town.

They've got people they've worked with for decades that they'll fund. They'll come in and have the same mismanagement. So, I'm hopeful that this Committee, whether through new laws or through some form of oversight, can make sure that imbalance gets rebalanced, and we put logic and reason back in the healthcare delivery system.

Thank you for your time and attention. I'd be happy to answer any questions.

[The prepared statement of Mr. Echols follows.]

PREPARED STATEMENT OF MICHAEL ECHOLS

Thank you for the opportunity to allow me to testify before your esteem Committee. The issue with Steward Health Group and Glenwood Regional Medical Center has created an imbalance in Northeast Louisiana and the healthcare delivery system. I have over the last year and a half seen the dramatic impact to patient care as well as the imbalance in the delivery system for rural hospitals because of Stewards negligence and malfeasance. After visiting with local physicians and patients it was alerted to me that there were major problems at Glenwood Hospital. The physicians had deep concerns about the lack of supplies, leadership issues, and other bad decisions that were being made by executives of Stuart health group who manage Glenwood Regional Medical Center and how it was impacting their ability to care for patients. Soon after these anomalies started being presented by physicians, Glenwood Regional Medical Center started to eliminate service lines such as labor and delivery, urologic care, major diagnostics such as MRI as well as other specialist services because of this mismanagement.

As a legislator I was inclined to have a hearing to discuss many of these issues in a public forum to allow individuals to express their concerns both the public as well as providers in the medical community. Prior to having a public hearing I was able to meet with Louisiana Department Of Health representatives such as Stephen Russo, who at the time was the Executive Counsel of LDH. There were numerous communications with them who in turn communicated with the Glenwood leadership team as well as Stuart exec at the time. You could easily determine that something was wrong after several months of back-and-forth and reading national publications about Stewards mismanagement and other markets. It was abundantly clear that there was a problem at Glenwood with many of the service lines being shut down, quality issues being reported other hospitals reporting issues with Glenwood.

After several months and transition of state administration for the department of health who took over soon after the January 2024 inauguration it was apartment Gelenwood and Stewart had transitioned from a series of small problems to major problems being placed on jeopardy status with the state and having their Medicare and Medicaid licensures in jeopardy at the Federal level. There were numerous accounts patient care was being compromised due to material shortages, no specialist care due to physicians was being paid and reports of patients being hurt or even dying because of not getting the care that they deserved or needed.

Due to all these reports of Stewart's negligence and gross malfeasance some weeks later I was able to establish a commission committee to meet and report from the community on April 9 of 2024 at the Louisiana legislature the Subcommittee of Health and Welfare was able to meet and receive testimony from community members.

Nurse practitioners, nurses, doctors regional hospital executives from St. Francis members from the LDH or the department of health executive team all presented what the impact was of Stuart mismanagement corporate malfeasances and non-investment in the property in Northeast Louisiana.

That hearing was revealing and that the president or CEO of Glenwood Jo Turton arrived and testified on behalf of Glenwood and Stuart in the audience, Mr. Puddy a southeast regional vice president of Steward was present as a legal council, but refused to testify. He was to come to the table but again he was scared and did not come to the table. Mr. Turton and his testimony validated that Steward was negligent as well as liable for not providing supplies, not paying vendors, not having a fiscal management and killing or maiming patients to which he admitted all these things on the record.

This testimony alone which can be found online is reason to hold Steward liable and corporately negligent for killing and/or maiming patients in Northeast Louisiana due to the fact that Steward and the greedy team of executives who stole money through whatever means possible in conjunction with Medical Properties Trust unjustly enriched themselves versus reinvesting back in provider pay vendor payments, and patient care.

All these things have created a massive imbalance in Northeast Louisiana healthcare delivery market. I hope that this Senate panel will be willing to hold these executives these corporate raiders who work between Medical Properties Trust as a quasi Ponzi scheme to acquire hospitals, distribute short term profits from over valuations and hold assets in a REIT thus separating ownership from operators in order to rape the healthcare delivery system and pillage the assets while holding them hostage through funny bankruptcy laws and a real estate investment trust that has no accountability to the community to hold an asset hostage. Steward and Medical Properties Trust has done this in numerous communities, asked for political bail outs and continue their Ponzi like scheme. These schemes persist and I'm hopeful the SEC will investigate MPT further along with the symbiotic relaitonship of the CEO of Steward and MPT. These two have scheduled to loot hundreds of millions of dollars through financial relationships while leaving patients to die on the table waiting to care.

I'm here today to answer any questions to reflect on the hearing that was held on April 9, 2024 in Baton Rouge. Thank you for your time.

The CHAIR. Thank you very much, Representative, and thank you for your work in being here today.

Senator Cassidy, what comes to my mind above and beyond the discussion we're having, Massachusetts is supposedly one of the progressive states, Louisiana, one of the conservative states, and we're hearing the same story, aren't we? We're hearing about decent, hardworking healthcare workers trying to maintain a rotten system based on outrageous greed. We're hearing communities being impacted whether Louisiana or Massachusetts, and we're seeing that all over the country.

I want to pick up on a point that every one of you made, and that is the spillover impact that the collapse of a healthcare facility has on other facilities in the region. In Vermont, Massachusetts, Louisiana, we're all stressed in healthcare. If a system closes down, if a hospital closes down, it's not like, "Hey, no problem. Other people will pick it up." So maybe just go right down the list. Mayor, do you want to start off? In your community, what is the impact on other facilities?

Ms. MITCHELL. Well, definitely the other two facilities in Ouachita Parish are overwhelmed. The ERs are full. The beds are full. So not only are the patients having to wait, but the employees that work there are stressed. They're overwhelmed.

The CHAIR. Say a word on that. And maybe somebody else, all of you mentioned this in one way or another. You have decent people. I'm always amazed. I have to tell you, I have had nurses in tears in my office, not worrying about their wages, but broken hearted that they cannot provide the quality of care they have been

trained and want to do. And what I'm hearing from all four of you is you have great workers, stressed out, overwhelmed. Who wants to talk about the impact of what Steward has done on the employees of the various facilities? Anyone want to jump in?

Ms. Sprague.

Ms. SPRAGUE. Hi. Thank you.

The CHAIR. Talk a little bit closer to the mic.

Ms. SPRAGUE. Yes. The impact for the healthcare workers, nurses, doctors, everybody, is you go there and you become for—I can speak as a nurse—you want to take care of people, you want to help people. Nobody's working this hard in this situation for any other reason. And when you have—in the emergency department where I worked—you have sick critical patients and not enough physical people to take care of them all, you have to go to the most emergent situation.

Which means that there's some poor little elderly woman in her bed that's in pain, that's not getting her pain medication or, incontinent and needs to be cleaned up. And in the back of your head, that needs to be done, but you can't physically get there and there's not a physical time to do it. And that those are the things that keep you up at night that you worry, you're like, "Oh my God, that poor woman." And it wasn't that you didn't want to, you just physically could not get to it because of the life-threatening things or the urgent things you have to prioritize.

It was everywhere at every level. Everybody was trying to make up for what Steward wasn't putting in and wasn't investing. We had to invest with our own work.

The CHAIR. I'm hearing that there has been enormous emotional toll on people who see suffering, who want to address it and are unable to do so.

Ms. SPRAGUE. Yes. Yes.

The CHAIR. Not to mention, one of you mentioned people actually taking money out of their own pockets to buy necessities. Ms. MacInnis, did you want to add to that or?

Ms. MACINNIS. Thank you, Senator Sanders. I have spent the past 12 years since we realized—it took us a little bit of time to realize what a bad player Steward was—and I've spent countless hours sitting across the table from Steward at least twice a month at staffing and labor management meetings and saying, "This is unsafe. This is untenable. We can't do this."

We represent hundreds of nurses who just sometimes struggle to come into work, to put one foot in front of another. It ruins you. A lot of people who used to work full time, 36 hours a week, cut down their hours. Now when people are that stressed, they just, they cut down their hours and they just don't feel like they can do it anymore. It's the moral injury that occurs when you're unable to do the one and only thing you want to do. And that's to keep patients safe and to take care of the best care that you can of a patient of all my patients.

But for the greed of Steward in the way they deliberately, and it almost feels malicious, deprive me of my colleagues, my support system, my supplies, my equipment. I'm just worn out.

The CHAIR. Thank you.

Senator Cassidy.

Senator CASSIDY. I would defer to Senator Romney.

Senator ROMNEY. Thank you, Mr. Chairman, and Ranking Member Cassidy. Appreciate the testimony we've heard and your willingness to bring this to our attention in a very clear and convincing way. Obviously, the events that took place under Mr. de la Torre's management at Glenwood and other facilities across the country, including by the way, five hospitals in Utah, was reprehensible and never should have happened.

Steward was operating in my state from 2017 to 2023. They understaffed healthcare facilities. They didn't pay for required medical equipment. They failed to meet minimum operating standards. They refused to pay a number of vendors to the tune of about $40 million to vendors in my state, and most importantly, they endangered lives. And it's hard to calculate precisely how many lives have been seriously affected or worse as a result of their mismanagement.

Clearly this kind of unusual setting warrants careful and thorough Federal review. HHS at the Federal level is responsible for conducting oversight to combat waste, fraud, and abuse. It appears that all three were involved at Steward. And I appreciate Chairman Sanders and Ranking Member Cassidy for bringing the issue before our Committee, but I regret we don't have someone here from the Administration either this Administration or the prior Administration to talk about, Okay, what should HHS be doing? How can we oversee, particularly in the case of hospitals in rural areas, that this doesn't happen? And, is there something that needs to be done at the Federal level to make sure that levels of care are being provided? Is there something done at the state level?

Now, I'll turn to you Representative, which is, what is, what happens at the state level? Is there some state oversight where state regulators lack in this regard? I don't know, to what degree the Federal regulators should have been taking more aggressive action or whether they had the authorities necessary to do that. But from your perspective, is there something that the state can do or should do or did not do that would've prevented either the tragedies in your state or perhaps in other states like mine that had been so gravely affected as well?

Mr. ECHOLS. At the time—and thank you for the question, Senator—the undersecretary, the secretary of LDH started investigating in November 2023, which led us up to the hearing in spring of 2024. They do have, through the medical jeopardy process the ability to suspend or terminate the license for the facility. And that's the path we were headed down with this particular situation.

Some states are more aggressive than others. I mean, when you look at shutting down a hospital and potentially hurting more people because of that, this is how both private equity and these facilities get away with these schemes, because they put your facility in jeopardy, they shut them down, your community has nothing. So, they suffer even more. So, then they can come to politicians like

you and me and ask for additional bailout money and other lifelines, which to me is part of the broader crime.

To answer your question, yes, there are pathways for our departments of health to hold them accountable, but the question is, is the pain worth more than the punishment?

Senator ROMNEY. Do you believe that additional Federal oversight is important or necessary in this regard?

Mr. ECHOLS. I think more broadly, when you look at how these schemes are funded, they come through—and Senator Sanders mentioned Medical Properties Trust—when they're fueling this private equity movement to be able to fund these schemes, then yes, there's Federal oversight. And it starts with the SEC. I'm shocked that a real estate investment trust can have such large ownership of a company like Steward. That's not how REITs function. Federal laws should prohibit those things.

There's a broader conversation on how you fund it. And then there's, maybe a less broad conversation around specifically with the Department of Health and Hospitals on regulatory environments that disallowed these types of operations to exist.

Senator ROMNEY. Great, thank you.

Mr. Chairman.

The CHAIR. Thank you.

Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman, very much. Behind me are pictures from the patients who died at Steward Hospitals in Massachusetts when Steward directed millions, tens of millions, hundreds of millions of dollars away from paying their bills and into the pockets of corporate executives. Ralph de La Torre, Cerberus, Medical Properties Trust were just sucking out tens, hundreds of millions of dollars for their own benefit and leaving these hospitals without the resources which they need.

Dirty ICUs, patients are bleeding out, they're dying in the hallway. Sunita, Theresa, Gilberto, David, Patsy, Michael, they were amongst the patients that our nurses were just referring to. And God knows how many others, whose names we don't even know. We know that more than 2000 patients were endangered by Steward Healthcare according to *The Boston Globe* Spotlight team. They were grandparents, parents, children, aunts, uncles, nephews, nieces, friends, community members.

But for those corporations, private equity, those profits came first, meaning the patients came last and ultimately just left it to the nurses to try to deal with this situation as it unfolded. And this was a situation where every patient meant something special to the families and to the nurses as they tried to help.

Ms. MacInnis, you saw the faces of these patients. Can you talk about——

Ms. MACINNIS. Yes, I saw——

Senator MARKEY. Can you talk about these people and their families and what the impact on them was?

Ms. MACINNIS. Patients die and patients become less well sometimes when they empty the—when they enter the hospital, and it's

inevitable and that's life. When a patient becomes less well or they die because the resources that they need were unavailable, that's greed. And when I think back over the years of the patients I was unable to care for in the emergency department, because one of the cardinal rules at Steward is you can never decline a transfer.

You might not have a bed in the hospital. You might have a 28-bed emergency department with five nurses and 35 patients. And when you get that call that a critically ill patient is coming, and you say, "I can't. I can't possibly prepare for or care for that patient." The nursing supervisor says, "Well, I'm not allowed to say no, so neither are you." And then you get that patient, and it's a gut punch to know that you won't be able to do for that patient what you know that patient needs.

Time and time again my organization—I personally, I've been to Beacon Hill. I've talked with people from DPH, EOHHS. We've reported power outages and other failures. They closed the ICU at—Steward closed the ICU mid-COVID at Nashoba Valley. And when the MNA reported them for closing it, the DPH called corporate and corporate said, "Oh, no, no, no, no, no. RIC was open. Not to worry." Even though it was dark in there, and there were no patients, and there were wires hanging out of the wall from where the equipment had been removed.

When the MNA called DPH and said, "Well, what did you find?" They said, "No, it's open. Steward said, it's open." So, then pictures were sent to DPH and said, this is clearly a closed unit. And DPH did nothing. DPH is a toothless tiger, and that's why we need this to be fixed at the Federal level. Every single entity that was closed in Massachusetts by Steward was deemed an essential service. And DPH said, "No, no, no, no, no, no, it's essential. You can't close that." And then they closed it anyway, and there were no ramifications. Nothing happens.

Senator MARKEY. What would you have done with the $800 million that Cerberus took out of the system? What would you have done with the $40 million that Ralph de la Torre used to buy his own private yacht? What could you have done with those revenues?

Ms. MACINNIS. We could have had beds that work. I mean, I work on the 10th floor of a building. There is supposed to be six elevators. One of them is working, a single elevator is working. They gave us these sleds, so we're supposed to do a lateral transfer, if there's a fire in the building, you go to the next building. And they gave us these sleds to drag patients who can't walk.

I'm 65 years old. Do you think for 1 minute I can haul a patient on a flight of stairs on a sled? This is lunacy. Six elevators and only one of the—and even that one works most of the time. So yes, if we had that money, we'd have a facility that's clean and where things function. We'd have beds for patients, we'd have stretchers, we'd have food, diapers——

Ms. SPRAGUE. Staff.

Ms. MACINNIS. Staff. All roads lead to staffing. If we had enough staff, we could make do with missing some other things. But for every person you take away from the bedside, you increase the risk to the patient who's left without care.

Senator MARKEY. Thank you for being here today. You are brave. And Dr. de la Torre is a coward.

Ms. MACINNIS. Absolutely.

Senator MARKEY. He would not come here to allow you to confront him with the reality of what he has left as his legacy at these hospitals.

Ms. MACINNIS. Thank you.

The CHAIR. Senator Markey, thank you.

Senator Cassidy.

Senator CASSIDY. I'll defer to Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman, and Senator Cassidy. This is just another egregious example of a broken healthcare system, when you can have a story like this. I just spent time with someone yesterday, and this was on an ERISA plan. I think the claim was about 4.2 million that the company had to end up paying the provider 875,000 bucks. And then the insurance companies and another middleman in it got nearly $3 million. And the owner ERISA plan had to end up paying that bill, didn't have enough transparency to actually make a decision that would've prevented it in the first place. And, who was suing the provider that only got 875,000 bucks and the insurance company's other middleman got over 3 million.

That should never be happening in a system. I fought it my entire career as someone wanting to offer great health insurance, took it on back 16 years ago. Proudest thing that I did was created healthcare consumers out of my employees. Didn't think that was reasonable to have your bill, your health insurance go up 5 to 10 percent each year and be told you're lucky. This is part of a broken healthcare system that even doctors and nurses and independent pharmacists don't want to get into anymore because it's been taken over.

When private equity gets into emergency rooms and gets into something, that's because it's easy cash-flow. That's Okay if you want to do it on something that isn't critical, if the marketplace allows it. Here, it ends up in a story like this. It ends up to where we're paying twice as much as most other countries are for healthcare. And in many cases we have poorer results. I give you that description of another aspect of the system that I just described. Look at how many resources are being wasted. And then you look at this egregious example, something's got to give.

Senator Sanders and I have put out a template based upon competition and transparency, getting rid of the barriers to entry. It would be a far bigger reform of a broken industry than what government has attempted to do in the past. And I think it ought to put the industry on notice, from insurance companies to hospitals, to the whole gamut. The only ones not liking the system or the practitioners that live within it and they're not happy about how it's evolved, is we have to do something to fix it from the ground up, or we're going to hear more of these tragic stories.

I got a question here. I'm going to ask it let me get to it here. It'll be for Mayor Mitchell. Told you about the bill we've got that's going to create strong transparency. It's going to engender competi-

tion. It's going to try to chip away at this story and others, and there's so many of them that make you sick. I'm wondering if greater transparency would've been helpful in the fiscal condition of Glenwood Regional. If there was more information for people to see out there, do you think it would've made it an easier navigation in terms of what you had to go through?

Ms. MITCHELL. Yes, I think so. And thank you for the question. Even now, as a board member, I mean, we didn't know it. It was always presented that Glenwood was profitable. It was actually one of the most profitable hospitals in the Steward system. We didn't even know. And there were rumors kind of in town, maybe the summer, late summer of 2023, about some local vendors not being paid or being slow to be paid.

But it really was not until September and October when it, the realization of the seriousness of the issue came about. And then all of a sudden, I mean, we were in immediate jeopardy in December. And at that point there was, not a whole lot that could be done on the local end of it.

I've been mayor 6 years. This is by far the No. 1 topic that I get calls, comments, texts, people I don't know stop me in the grocery store asking, "Please do something about this." And it just all came to head kind of just all of a sudden. So, transparency would definitely, I think, help the situation.

Senator BRAUN. I think until healthcare consumers who have atrophied within a broken system that many times are fearful that their own insurance plan is going to be there for them after they get the bill four to 5 months later, it's all got to change.

Ms. MITCHELL. Agreed.

Senator BRAUN. If it's not involved with an engaged skin-in-the-game consumer and a system that if they want to call themselves free enterprise has to start responding. Otherwise, you're going to see this egregious issue, many others like I described. And then yes, a system that could still be repaired will have to be run like every other country does it. Industry wake up. Thank you.

Ms. MITCHELL. Thank you.

The CHAIR. Thank you very much.

Senator Hassan.

Senator HASSAN. Thank you, Mr. Chairman, and Ranking Member Cassidy for holding this hearing. Before we begin, it's absolutely unacceptable that Dr. de la Torre has defied a subpoena from this Committee and isn't at today's hearing. The American people deserve to hear answers directly from him on the horrific mismanagement of Steward Healthcare.

Ms. Sprague and to all the witnesses, thank you for being here. To our nurses in particular, thank you for what you have done throughout your professional careers. Nurses keep our healthcare system going and they save patients every day and they comfort patients every day. And we are very, very grateful to you.

Ms. Sprague, I want to discuss your experience at Nashoba Valley Medical Center, which is located in Massachusetts just about 10 miles from the New Hampshire border. And Southern New Hampshire Medical Center in Nashua about 18 miles away, is like-

ly to be one of the healthcare facilities that now has to absorb the impact of the closing at Nashoba Valley.

When Nashoba Valley Medical Center announced abruptly at the end of July, that it would be closing in August, leaving just a month for patients and staff to prepare for this massive change in their community, I am curious about what patients and staff at Nashoba were told in the weeks leading up to that closure.

Ms. SPRAGUE. From Steward Corporate, very little. We got the WARN notice that was sent to the MNA that wasn't sent directly to each of the employees because they don't have to if you're a part of the union. So that's how the notification came of the closure to begin with. That was on July 26th. On August 2nd, so 5 days later we got—well, five business days, so a full week later—we got the first email from corporate Octavia Diaz that said, pretty much, "I'm sorry. Like, we tried, but we're going to close anyways. It's not our fault. Nobody bid." Which everything was done in complete secrecy.

They kept saying no viable bids. But nobody knows what that means or what that entails. And they just closed. We had a town hall meeting, which is like a—we did it by phone with our CEO, but even they weren't given a ton of information from corporate. And that's it. We never had another interaction from corporate to all of the employees, like that was sent to us. Everything's closed now.

Some of the doctors have left, like the specialists, the endocrinologists have left. I know about it because I work in the hospital and I know like what's going on as being part of one of the co-chairs of the union. But I have never gotten a letter from the hospital saying that there's no longer a diabetes and endocrine center. So a lot of people don't know.

I know that there's nothing in check for them and how they got here, I don't understand because if I don't do my job, there is a very strict system that will pluck me out of practice to keep patients safe. So how private equity comes in and just can do all of this to all of these people with no systems in place, it's crazy to me.

Senator HASSAN. Right. Because patients are going to have to travel farther——

Ms. SPRAGUE. Much farther.

Senator HASSAN [continuing]. To receive care in our region. It puts a massive strain on nearby hospitals and local EMS, including as I pointed out in my state. Can you speak just briefly—I want to ask you two things. Talk to me about the impact that you have seen or you're hearing from your colleagues in the nursing profession on other hospitals in the region as they have to work to absorb hundreds of patients from Nashoba. And then also, I understand that you all tried to push back and protest the closing. And I'm curious about how Steward responded to that.

Ms. SPRAGUE. Steward had no response to it at all. We never heard anything from them. They just went on with their day. And because they don't think that they care at all. It was of no consequence to them of what they were doing to every employee and every person that gets care at our facility, how it was at every level going to affect them. And people had no transportation, no way to

get there. They had no knowledge of it. And I guess there's some helpline that's set up for, I don't know, a few hours a day, but I'm sure it's wholly inadequate if Steward is in charge of setting it up, and they just had no help and no time, because they wanted to get it done in 30 days, because then it's less debt, less money that they have to spend to keep this hospital open.

There was no time to increase the staffing. For all the EMS, all the towns, most of them have one or two, ambulances aren't staffed. Now their transport times are double, triple to get someplace where they're out of service much longer. Meaning that there's not another ambulance crew available for the people in that town. And most of them are also the firefighters. So now you don't have firefighters in town for that. And the other hospitals around are having to absorb the patients.

Then as the employees who have lost our jobs, now we have to go work in that setting where they're overwhelmed because how far can we go when we're not going to drive hours and hours to go where these hospitals aren't affected. So now I have to go work in an emergency department if I want to stay an ER nurse, which I do, that's more overwhelmed than it was before. And so, it's just so multi-layered, and it's things you don't even think of. You're like, "Oh my gosh." Even a month later, I'm like, "I didn't even think of that."

They don't care that nobody in our area, 16 communities that are serviced, they have literally nowhere to go and it will cost lives. And they know the state and they know it's wrong, and they know that Steward lied about everything always. And they still got to just do whatever they wanted. I don't understand it.

Senator HASSAN. Well, thank you. I'm over time. I want to just comment to Ms. MacInnis. I had a question about how things have changed at St. Elizabeth's, and you've already answered that multiple times. But Mr. Chairman, as somebody with family in the Boston area, I just want to say that St. Elizabeth used to have a reputation as being a wonderful, wonderful hospital, especially for moms and babies. And to hear your stories shakes me to my core. And I thank you for being willing to share it. I thank all of the panelists for being able to, as Senator Markey pointed out, be brave enough to be here today when the person who should be here today is not. Thank you.

Ms. MACINNIS. Thank you, Senator.

The CHAIR. Thank you, Senator Hassan.

Senator Cassidy.

Senator CASSIDY. Hey, Mayor Mitchell and Representative Echols, I want to enter into a conversation with you.

Mayor Mitchell, you were on the community board. Did they ever show you financials?

Ms. MITCHELL. Financials were passed out each month. I'm not an expert in healthcare finance, but they were passed out every month. And it did show that the hospital was profitable.

Senator CASSIDY. Now was it profitable on a margin? Was it profitable like, "Oh my gosh, you got some operating capital here?"

Ms. MITCHELL. It was, I think, more marginal.

Senator CASSIDY. Now I'm struck, and this may be for Mr. Echols, but we are hearing that they never went on divert in Massachusetts, that they would accept a patient for transfer even if they didn't have a bed.

Ms. MACINNIS. That's correct. Yes.

Senator CASSIDY. But it took our health and hospitals to make them limit their—now I'm a physician. I know that's because you didn't have staffing. If you don't have staffing, but you're still taking patients, then you're putting the patient in danger. I'm just going to say that.

Did they ever discuss why they would not limit their number of beds without the state making them do so? Because presumably staffing had become an issue and that's why the state limited it.

Ms. MITCHELL. When I first called LDH, which would've been probably late October, December, or November, telling them we need help, I was told it was a private industry, private business, free enterprise, and until certain types of complaints were made, that there really wasn't a lot that could be done. An extremely helpless situation knowing that, things were not great in the hospital. And it took, I think, a different type of complaint. I think a patient or maybe a physician made a complaint to LDH and it took that to get LDH to send surveyors to Glenwood to assess the situation.

Senator CASSIDY. The specific complaint was about staffing ratios, regarding the paucity of equipment? Tell me.

Ms. MITCHELL. I think it was more about the lack of supplies.

Senator CASSIDY. Lack of supplies. Now Representative Echols, one of the things I'm interested in, is a lease arrangement between Medical Properties Trust and the hospital. And I think you've reviewed some legal proceedings which have taken that, which would otherwise be proprietary and has now become public. Were there market rates being paid for the lease, or were there above market rates? Can you give us a sense, because I'm trying to—where is the hole in the bottom of the bucket? They're making money even on the margin, and yet there's some hole where the money's dripping out.

Mr. ECHOLS. I think it all starts at the top. So, as I understand it and was reported by the Department of Health, that the lease between Steward and Medical Properties Trust was equivalent to $10 million a year. So, a property like Glenwood, $10 million a new year is an enormous amount of money.

Senator CASSIDY. Is that market rate or is that above market rate?

Mr. ECHOLS. It's above market rate.

Senator CASSIDY. Do you have any sense, is it marginally above, 10x above? Are you seeing what I'm saying?

Mr. ECHOLS. I think it's at least 2x.

Senator CASSIDY. 2x.

Mr. ECHOLS. That's on the high end. $5 million a year would be a high lease for that type of property with a deferred maintenance and other issues. Steward, which is of course responsible when a

REIT owns an asset, the lessor, whoever's leasing the building, would typically be in charge of making improvements to physical plant. They have to keep that for their SEC rules.

In this case, they should have been investing back in the hospital. There's tens of millions of dollars of deferred maintenance in that facility.

Senator CASSIDY. Let me stop you for a second, because in our investigation, it looks like MPT has for Steward in general, has through forbearance of loans or just cash, returned about $200 million to the system. I'm trying to be impartial here. I'm trying to figure out what's actually going on. So, you could argue that they were putting the money back in the system to try and float the boat. But Mayor Mitchell, was there any—could you see from the community board, or Representative Echols from your investigation, that any of this money was put back into that deferred maintenance et cetera?

Ms. MITCHELL. No. You could walk in the medical mall or the hospital now, and there'll be buckets—especially with the rain that's come through the last couple of days—there'll be buckets in the hallway catching water because of the leaks. I was in the medical mall last week and you had to walk around, things like that to get to the facility where I needed to get a test.

Mr. ECHOLS. Steward executives required employees, PTs, doctors, nurses to go around and cleanup the hospital, physically cleanup, sweep, mop to try to prepare for this next round of liquidation, I guess, as they're bringing in suitors to try to take over this lease.

Senator CASSIDY. Let me stop you because I just have seconds left.

The CHAIR. You got time.

Senator CASSIDY. I keep on hearing corporate, corporate, corporate. Am I gathering that local decision-making, that you couldn't say, "By the way that we need another coil to embolize a bleeding adenoma in the liver." You had to go to corporate to get them to pay for that. So, Mayor Mitchell, again, you're on the Community Advisory Board, is our impression correct that local decisions had to be made corporately?

Ms. MITCHELL. Yes. And so many of the different departments got moved out of the hospital. So it was even harder to get a decision or to get a response or to get anything done.

Senator CASSIDY. What was the means of communication? Was it a kind of formal discussion, listen, here's our to-do list and here's our needs list, or was it more ad hoc?

Ms. MITCHELL. It was really more ad hoc. I mean, the community advisory board, I mean, we were not in the day-to-day operations, obviously we're not in those decisions. It was more of a here's what's going on in the hospital type situation.

Senator CASSIDY. Well, I'm going to—the Chairman has generously allowed me to go a little bit over. But before I end, I want to thank the nurses. I used to work in a hospital, which was publicly run and always at the end of the fiscal year, we didn't have money for things, but it was the committed staff that made it work.

And I just like my heart's beating with yours on everything you've done.

Thank y'all. Thank y'all.

The CHAIR. Thank you, Senator Cassidy.

Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chairman. First do no harm. That's connected to the Hippocratic Oath. And Dr. de la Torre went to medical school, became a doctor. I mean, it raises the question, how can he be Okay with the business decisions he made and how can he stand behind them? Thousands of workers laid off because of Dr. de la Torre's shoddy business practices and mismanagement of Steward Health's hospitals and closures.

Four hospitals in Massachusetts alone laying off 2,500 employees. And at a time when we're so worried about healthcare employees, we're somewhere in the vicinity as many as 6.5 million could leave the profession by 2026, by the end of 2026. And we have in the best, most of optimistic pipeline, a couple million to replace them. And I think that gross mismanagement is not only impacting current workers lives, but it's also affecting future potential workers, young people that would have considered going into this.

Ms. MacInnis and Ms. Sprague, how do we go about battling back? How do we re-institute the efforts to inspire high school students who might be interested in science or open to medicine to get them to go into healthcare even in what appears to be such an unstable environment, and within Massachusetts obviously, it's going to be a distraction and a deterrent for young people to get into healthcare.

Ms. MACINNIS. I'd like to respond, if I may. We need legislation. We need safe patient staffing legislation. We need safe patient handling legislation. So, the equipment is always available to move patients around. And we need safe environment legislation that would make it a crime to harm a medical worker. I worked 20 years in the ER, I have lost count of the number of times I've been assaulted.

Ms. SPRAGUE. Absolutely.

Ms. MACINNIS. We just don't have access to lifting equipment. And any time a nurse takes care of more than four patients on a med surg unit, the odds of one of those patients dying increases by 7 percent. We cannot keep doing this. Five and six and seven patients, you cannot give good care. All the scientific evidence is four patients is doable. As long as we are bringing new nurses into this environment and OTs and PTs, and we're making them care for too many patients, they're going to turn around and they're going to leave.

Nobody's going to stay and work in this environment. The Commonwealth in Massachusetts, we have 20,001 nurses now than we did at the beginning of COVID. Just to be clear, there is no nursing shortage in the Commonwealth in Massachusetts. There is a shortage of nurses who want to work in unsafe situations.

Ms. SPRAGUE. I agree 100 percent with what she's saying. And, to have healthcare in hospitals be for-profit means that nurses aren't a billable service. So, if you're trying to make a profit, the

same amount of work has to be done at the end of the day, whether there's one nurse to do it or 10 nurses to do it. So, there's no incentive for a for-profit company that's looking to get every dime out of the hospital and all the services, to add more nurses. They don't care how your day is. They're not there to actually help patients. They're there to make money.

Until it's not for profit and it's actually for the patients, then they will put more nurses on because it's not, wherever the funding comes from to help the hospital so that they can provide the correct amount of staff. Because no for-profit company is going to do it out of their own pockets, obviously because they want the profits for them. It's just they've lost sight of what it's for. We're not a company that's putting handles on buckets, like, it's people and it matters. It's their lives, it's your family, my family.

Any of the people that are actually owning these companies, they'll never be in that situation, because they're going to go to the VIP section. They're going to be, "Oh, this is the CEO of whatever, blah, blah, blah." They're going to be taken to the best room. They're going to be taken quickly out of—so they'll never know what it's really like where the rest of the people that are there in their hospitals are the ones suffering from their choices.

Senator HICKENLOOPER. I'm out of time, but it's compelling. I mean, obviously something's got to give.

The CHAIR. Well, thank you for your questioning, Senator Hickenlooper. And I think the issue that you raised is, if you're a young person interested in going into healthcare, do you want to walk into a disaster like that at a time when we desperately need young people to do it. It's a very important point.

The other point that I would pick up on is what Senator Braun made a moment ago, that in the midst of everything that we are talking about today, please don't forget, we are spending twice as much as what other countries spend per capita over $13,000 for every man, woman, and child in America. And this is what we are getting.

Senator MURPHY.

Senator MURPHY. Thank you very much, Mr. Chairman. Thank you all for being here. This is a very important hearing. It's important because, well, we are focused on this particular company and this set of horror stories. What is happening in your hospitals is happening all across the country. I wish this were not true, but there are hundreds of Ralph de la Torres who are making a disgusting fortune off of withholding healthcare from people in need.

I just want to tell you a quick story about what's going on in Connecticut. In 2016, a company called Prospect Medical Holdings that is owned by a private equity company, Leonard Green and Partners bought three hospitals in Connecticut, three small hospitals, Manchester Hospital, Waterbury Hospital, Rockville Hospital. You know exactly what happened. Immediately, they started stripping services out of these hospitals. Same story you're telling. All of a sudden, supplies started running short. All of a sudden, specialists couldn't be found because they were cutting them off of

the rolls. The elevators stopped working in these hospitals just like they did in your hospitals.

By 2018, these hospitals were in trouble. Everybody knew it. Prospect was looking for a new buyer to just flip the hospitals to make more money. In that year, in 2018, Leonard Green took $658 million in fees and dividends. As these three hospitals in Connecticut were essentially dying in front of our eyes, patient quality was being compromised.

John Danhakl is the managing partner of Leonard Green. There's a lot of various reports about how much he's worth, but likely in the neighborhood of a billion dollars. I mean, how have we let American capitalism get so off the rails? So, unmoored from the common good that anybody thinks it's Okay to make a billion dollars off of degrading healthcare for poor people in Waterbury, Connecticut. A, how do you live with yourself? But B, why do we accept that as a country?

This is just a choice to decide to commoditize our healthcare system, in Connecticut, in Louisiana, in Massachusetts, in every state across this country. And we have enough data at this point to know quality is worse, often way worse when these private equity companies come in. And not just in hospitals, in nursing homes, the death rate in nursing homes owned by private equity companies is 10 percent higher than in those not owned by private equity firms. So, there's no mysteries of what's going on here.

Ms. MacInnis, I wanted to just ask you a simple question. You've talked about this before, but I mean, let's acknowledge that every hospital has to make money, right? You have to make money in order to operate. So, nobody begrudges a hospital for making decisions that allow it to make more money than it puts out.

The question is this, are you making money for the purpose of providing good healthcare, or are you making money for the purpose of making the owners filthy rich? And every decision that happens in a hospital is different, if you are making money to provide good healthcare versus making money to make the owners filthy rich. You were there before and after.

Ms. MACINNIS. Yes, I was.

Senator MURPHY. Just in the remaining minute, tell us a little bit about what it was like on the ground floor before this company comes in, right? And then after the company comes in. Can you feel it as an employee, the difference in the value system of the owners?

Ms. MACINNIS. Yes. It's noticeably different. I used to work on an interim coronary care unit, and we gave the best care. We took care of some of the sickest patients outside the ICU, and we gave the best care. We had a one to three, a one to four ratio. I never, ever, ever, in the two and a half years that I worked on the floor, we never had a code. And that's because we were able to rescue our patients. We had enough eyes, enough hands, good assessments, good monitoring, enough nurses around, frankly, because——

Senator MURPHY. Because the focus was providing good care.

Ms. MACINNIS. Because the focus was—yes. And when things got tight, what Caritas Christi did is they let go assistant nurse man-

agers, and then they let go other people. The very last thing that they did, and they actually never did, was get rid of staff nurses, get rid of bedside nurses. They kept us well staffed, and we took the best care of our patients. I was so proud to work at St. Elizabeth's.

After just Steward took over, it's just axe and axe and just taking away everything, violating agreements that they made with us, they laid off all the nursing assistants on our maternity floors. Imagine running a maternity floor with no—well, I can tell you as a nurse, it's an absurd prospect. They lay off our educators. Now they're cutting right where—for patient facing staff.

Whereas Caritas Christi absolutely prioritized that to the point where they stopped funding our retirement plan. They took away a lot of other things before they took anything away from our patients.

Senator MURPHY. Because the purpose is making as much money to make the owners filthy rich. Right? And it's just when there is a fundamental difference in the purpose, there's a fundamental difference in what happens inside that hospital. And that's just the reality.

Ms. MACINNIS. Yes.

Senator MURPHY. Thank you.

Ms. MACINNIS. Absolutely.

The CHAIR. Thank you, Senator Murphy.

Senator Cassidy, did you want to—I think we have come to the end. Did you want to have unanimous consent or?

Senator CASSIDY. Yes, thank you. I ask unanimous consent to enter into the record the letter we received from Dr. de la Torre, and the Committee's response to that letter.

The CHAIR. Without objection.

[The following information can be found on page 38 in Additional Material:]

The CHAIR. Let me very sincerely thank all four of our witnesses. Thank you for what you have done for your hospitals and your communities. And thank you for telling the American people what has been going on with Steward Healthcare. And I'll pledge to you, and I think I speak for Senator Cassidy as well, we are going to pursue this. This is not the last discussion of this. And if Dr. de la Torre thinks that he is comfortable by not being here today, Dr. de la Torre, if you're watching, you're wrong. This will be pursued.

With that, let me thank everybody for participating. I once again note that Dr. Ralph de la Torre, CEO of Steward Healthcare did not comply with the HELP Committee's subpoena and attend the hearing today. I ask unanimous consent to enter into the record a statement from Senator Casey, from stakeholders in support of the Committee investigating this matter.

[The following information can be found on page 35 in Additional Material:]

The CHAIR. For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, September 26th by 5 p.m.

This Committee stands adjourned.

ADDITIONAL MATERIAL

STATEMENT FOR THE RECORD OF SENATOR ROBERT P. CASEY, JR.

Chair Sanders, Ranking Member Cassidy, thank you for convening this important hearing to discuss the bankruptcy of Steward Health Care and the impact of these bankruptcy proceedings on local communities. I am disappointed that Dr. de la Torre defied the subpoena this Committee authorized and has chosen not to appear today. I hope that the Committee will be able to hear from him soon.

I would like to highlight the experience of a community in Pennsylvania, the town of Sharon, which is in Mercer County. Sharon has experienced many struggles in recent years, but the local community has been working hard to revitalize the town and promote economic growth in the region. Key to those efforts has been the Sharon Regional Medical Center, which is one of the largest employers in the county. Sharon Regional Medical Center is owned by Steward Health Care, the only hospital that Steward still owns in Pennsylvania. And now, this hospital is at risk of closing due to the bankruptcy. Closing Sharon Regional Medical Center would have devastating consequences on the local community.

The Sharon community's experience highlights the precarity of too many of our community hospitals, institutions that are pillars of their communities, supporting jobs and providing local, life-saving medical care. It calls into serious question the role of private equity and complex corporate ownership structures that are increasingly wading into the health care sector, placing profit above people. Many smaller community hospitals and rural hospitals continue to face financial burdens exacerbated by the pandemic and cannot survive when those burdens are compounded by corporate greed.

To illustrate how important it is that we keep community hospitals in the hands of their communities and with their doors open, I am including three letters from members of the local community about the importance of Sharon Regional Medical Center, which are illustrative of how vital the hospital is to the local community.

Several of their thoughts stood out to me. One physician in the community wrote, "Instead of a growing, robust medical community, we find ourselves having to send our patients further and further for specialty care, or our patients must wait for months to be seen locally." The head of the local federally Qualified Health Center network said, "Community hospitals play a crucial role in coordinating care and ensuring continuity for patients with complex health needs. The loss of this resource would disrupt established care plans, complicating the management of chronic diseases and increasing the risk of adverse health outcomes." And the Sharon City Manager wrote, "The city of Sharon has finally reached a turning point in a robust revitalization movement. The effect of the loss of the City's medical system and one of the county's largest employers would stall and set back that movement which has been of vital importance to the future growth of the city, valley, county, and region."

As you can see, the impact of a hospital closing can be devastating to the community. I am grateful that the Committee on Health, Education, Labor, and Pensions is taking a serious look at how we ended up facing this situation, and thinking about what we can do to support community hospitals remaining in the hands of their community members and serving the community.

DEAR SENATOR CASEY:

I am a primary care doctor employed by Steward Medical Group, now Stewardship Health, though, like the other primary care clinics in the Steward system, we have now been acquired by Rural Healthcare Group (a Tennessee-based firm owned by Kinderhook Industries, LLC—another for-profit, private investment firm). I became a primary care doctor because the health of my neighbors and community is important to me. I have practiced medicine in Western PA for over 20 years now, and I love the area and the people of rural Pennsylvania.

Sharon Regional not only provides health care for the people of Mercer county and surrounding regions, but it is the largest employer in Mercer county, with approximately 1800 employees. As a primary care physician, I do not work directly for the hospital, but I feel more than comfortable sending my patients there for inpatient care when they are ill, and to specialists who utilize the hospital for procedures and surgeries.

During Steward's tenure, I have seen the closure of our regional cancer center and our maternity ward and OB/GYN services. These were "business decisions" that were justified, we were told, by underutilization; this does sound legitimate, given the closures of these kinds of medical services all over rural Pennsylvania. However, the lack of services did not stop there; increasingly, we noticed surgeries and cardiac procedures getting canceled due to lack of supplies because vendors weren't getting paid. In our own clinic, we and our staff took up janitorial work for the same reasons—emptying garbage cans, mopping floors, and cleaning toilets because the contracted janitorial service had not been paid. Most concerning was when some of our specialists, with whom we had forged trusting bonds, left because they were unable to perform the procedures they were trained to do due to lack of surgical supplies. Instead of a growing, robust medical community, we find ourselves having to send our patients further and further for specialty care, or our patients must wait for months to be seen locally. Now, we worry daily about the future of Sharon Regional Hospital, which is the hospital that we, as Steward employees, must also utilize for our own health care. As a primary care group, we don't know if we will have any specialists left locally to refer our patients to if the hospital should close. And as for future doctors and nurses who may have wanted to train and settle down and work here? Well, due to the bankruptcy, the nursing school—which has been in existence here for over 150 years, had to close, and the Family Practice residency program at Trumbull—the other Steward hospital in the PA/Ohio area—is in jeopardy. There is no other hospital in our area that would be able to absorb the patient load that would be left in the wake of a closure of Sharon Regional; and, as mentioned before, our community would be further devastated by the loss of jobs.

I will say that the health care workers and support staff at our hospital and clinics are the most dedicated, compassionate, hard-working, and professional group of people I have had the pleasure to work with. It has been disturbing and devastating to read about the downfall of Steward and the behind-the-scenes financial manipulations that brought us to this point. Health care is not just a business to us; it is a calling to care for our fellow human beings. It is sacred work. A hospital is not some "asset" to be bought and sold—it is one of the cornerstones of a community, providing aide and comfort to everyone when most vulnerable. There should NEVER be an instance when corporate interests outweigh the health care needs of our communities.

I took an oath to lead my life and practice my art in uprightness and honor. I know I speak for my physician colleagues, as well as my nursing and support staff, when I say that I wish those to whom we had entrusted the health and lives of our patients, our community, and ourselves had chosen to lead us in a similarly honorable way. Instead, we feel let down, taken advantage of, and used like so many pawns on a chessboard in a game that enriched the few at the top, and left our communities devastated.

Thank you for your time.

HONORABLE MEMBERS OF THE SENATE:

Thank you for the opportunity to address this critical issue on behalf of Primary Health Network, the largest community health center in Pennsylvania and one of the largest in the Nation. The potential closure of a community hospital, like Sharon Regional Health System, would have profound and far-reaching impacts on our health center and the communities we serve. Here's a summary of the repercussions we would face:

1. **Loss of Specialty Care Providers and Delayed Referrals**: The closure of a community hospital would result in the immediate loss of specialty care providers who are crucial to our healthcare system. Their departure would greatly reduce access to specialized medical services and lead to increased delays in referrals. Patients would face longer wait times for necessary care, potentially causing conditions to progress and complicating treatment. This strain on our already limited resources would force patients to travel long distances for care, or, in some cases, forgo it entirely.

2. **Increased Pain and Suffering**: The lack of a nearby community hospital means longer travel times and greater logistical challenges for accessing emergency and routine care. This can exacerbate health conditions, particularly for those with chronic illnesses, the elderly, and individuals with limited mobility, leading to increased pain and suffering.

3. **Economic Impact on the Community**: The closure would have significant economic repercussions, including job losses and decreased local eco-

nomic activity. Community hospitals are major employers and economic contributors, and their closure would ripple through the local economy, impacting jobs and economic stability.

4. **Psychological and Social Effects**: The stress and anxiety caused by inadequate access to healthcare can profoundly affect the mental health of our community. Patients may experience increased psychological distress due to the uncertainty and difficulty in obtaining care, impacting their overall quality of life.

5. **Disruption of Continuity of Care**: Community hospitals play a crucial role in coordinating care and ensuring continuity for patients with complex health needs. The loss of this resource would disrupt established care plans, complicating the management of chronic diseases and increasing the risk of adverse health outcomes.

In summary, the closure of a community hospital would have devastating consequences, including the loss of essential specialty care providers, delays in specialty care, increased pain and suffering, economic decline, and significant psychological and social impacts.

We urge you to carefully consider these repercussions and work toward solutions that preserve and enhance the availability of essential healthcare services in our communities.

Thank you for your attention to this important matter.

Sincerely,

DR. GEORGE GARROW,
CHIEF EXECUTIVE OFFICER,
PRIMARY HEALTH NETWORK.

ROBERT G. FISCUS CITY MANAGER,
SHARON, PA,
September 9, 2024.

RE: **Potential Closure of Sharon Regional Medical Center, located in Sharon—Mercer County, PA**

DEAR SENATOR CASEY:

With the potential closure of Sharon Regional Medical Center (SRMC), located in Sharon, PA, this letter is to address the concerns pertaining to the extremely negative impact this situation could have on the Shenango Valley, the heart of the most populated area of Mercer County, and surrounding areas. The city of Sharon has finally reached a turning point in a robust revitalization movement. The effect of the loss of the City's medical system and one of the county's largest employers would stall and set back that movement which has been of vital importance to the future growth of the city, valley, county, and region.

The negative impact of the potential loss of SRMC in summary:

- **Loss of Essential Local Healthcare**: The absence of a full-service healthcare provider will necessitate that Shenango Valley/Mercer County residents in need of essential and/or specialized medical care would now need to travel an hour and a half to Erie, Pittsburgh or out of state into Ohio.
- **Countywide Job Loss**: SRMC is considered one of the largest, if not the largest, employers in Mercer County and, if closed, the loss of jobs would devastate the city, county, and region. The unemployment rate would rise, impacting workforce opportunities which, in turn, would push residents to leave the county to pursue medical-related jobs elsewhere. Losing SRMC also has the potential to negatively impact the housing market with those unemployed or underemployed at risk for home foreclosure.
- **Emergency Medical Response Impact**: Local private ambulance services' out-of-service time will increase as the usual local EMS transport time will increase significantly, further damaging an already fragile emergency medical system. Mercer County is already stressed with ambulance shortages, and the additional out-of-service times will inevitably lead to more instances of not having local ambulances available. Additional drive time may also increase the cost of EMS transport to Mercer County residents.

- **Behavioral Health Impact**: SRMC is the only local inpatient behavioral health provider in Mercer County. In its absence, patients will be displaced to UPMC Western Psychiatric in Pittsburgh or Penn Highlands in Dubois. Besides transportation challenges for patients and their family members, this will send money provided by the Mercer County Behavioral Health Commission out of Mercer County to those providers, further damaging the local/regional economy.
- **Local Financial Impact**: The City of Sharon would potentially lose (at minimum) 5 percent of the City's annual operating budget which comes from revenue directly related to SRMC, and the indirect economic damage would negatively impact the City's already challenging budget constraints. The necessary budget cuts would equate to a reduction of city services and reduced personnel complements, which could equate to less police officers, firefighters, and public works employees, among others.
- **Municipal Impact**: The absence of a local healthcare provider would create an additional burden on our municipal police and fire departments with increased demand related to longer service times for out-of-town emergency medical and behavioral health transport. In addition, this increased demand would come at a time when deep emergency service reductions would be necessary to avoid municipal bankruptcy.

Per the points above, this situation has the very real potential to negatively impact our city, community, and county for years to come.

Thank you for your attention to this important matter and advocation for a positive resolution.

Sincerely,

ROBERT FISCUS,
SHARON CITY MANAGER.

QUINN EMANUEL, TRIAL LAWYERS,
WASHINGTON, DC,
September 18, 2024.

Hon. BERNIE SANDERS, *Chairman*,
U.S. Committee on Health, Education, Labor, and Pensions,
Washington, DC.

Re: Senate HELP Committee Subpoena to Dr. Ralph de la Torre.

DEAR SENATOR SANDERS:

We write to follow-up on our September 4, 2024 letter ("Letter") to the Senate Health, Education, Labor, and Pensions Committee (the "Committee") and the Committee's recent announcement that it intends to vote this week on two contempt resolutions regarding the July 25, 2024 subpoena issued to Dr. de la Torre, in his capacity as Chairman and Chief Executive Officer of Steward Health Care System LLC ("Steward"), for testimony at the Committee's September 12, 2024 hearing titled "Examining the Bankruptcy of Steward Health Care: How Management Decisions Have Impacted Patient Care" (the "Hearing").

Dr. de la Torre lacks the authority to speak on behalf of Steward with respect to the ongoing bankruptcy proceedings and he is prohibited by a Federal court order from doing so. Despite these valid objections, however, the Committee moved forward with the Hearing without meaningfully considering the issues that Dr. de la Torre raised and without attempting to reschedule the Hearing. What is more, the Committee's disregard for Dr. de la Torre's request to reschedule the Hearing in light of these legal restrictions substantiated our concern that the true purpose of the Hearing was not to gather facts within the Committee's constitutional and congressional remit, but instead a pseudo-criminal proceeding with the goal of convicting Dr. de la Torre in a court of public opinion.

Our concerns that the Hearing would be used to ambush Dr. de la Torre in a pseudo-criminal proceeding were on full display last week, with the Committee soliciting testimony from witnesses calling Dr. de la Torre and Steward executives "health care terrorists" and advocating for Dr. de la Torre's imprisonment, all while the Committee refused to even acknowledge or aid the bankruptcy settlement that would ensure continuity of services in all but two Steward hospitals across the Nation.

Dr. de la Torre cannot be permitted to provide sworn testimony at this time, given that the Hearing was seemingly designed as a vehicle to violate Dr. de la Torre's

constitutional rights, including his Fifth Amendment rights. The U.S. Constitution affords Dr. de la Torre inalienable rights against being compelled by the government to provide sworn testimony that is specifically (yet baselessly) sought to frame Dr. de la Torre as a criminal scapegoat for the systemic failures in Massachusetts' health care system. Accordingly, on the advice of counsel, Dr. de la Torre invokes his procedural and substantive rights under the Fifth Amendment of the U.S. Constitution, including the privilege to refrain from testifying at the Committee's Hearing. *See Quinn v. United States*, 349 U.S. 155, 161 (1955). ("Still further limitations on [Congress's] power to investigate are found in the specific individual guarantees of the Bill of Rights, such as the Fifth Amendment's privilege. . . ").

If the Committee had any concern for the hospitals affected by Steward's bankruptcy proceedings it would, consistent with Dr. de la Torre's request to postpone the hearing for a more appropriate time, permit the bankruptcy resolution to move forward and focus its actions on tackling legitimate questions in the best interests of Steward patients, hospitals, and communities.

Sincerely,

ALEXANDER J. MERTON

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
WASHINGTON, DC,
September 25, 2024.

ALEXANDER J. MERTON, *Partner*,
Quinn Emanuel,
Washington, DC.

DEAR MR. MERTON:

We write in response to your letter of September 18, 2024. As explained in our letter of September 5, 2024, your client, Dr. Ralph de la Torre, had a legal duty to attend the hearing of the U.S. Senate Committee on Health, Education, Labor, and Pensions on September 12, 2024, as commanded by the duly authorized Committee testimonial subpoena issued to him on July 25, 2024, for which you accepted service on his behalf and indicated his availability.

As further explained in our September 5, 2024, letter, had Dr. de la Torre appeared to testify, he would have had a full opportunity to assert his Fifth Amendment right against self-incrimination in response to questions posed to him by Members of the Committee that implicated that right. Having elected not to appear, Dr. de la Torre willfully placed himself in default of the Committee's subpoena. Your effort to assert the Fifth Amendment, on your client's behalf, after the fact, and generally rather than in response to specific questions, is untimely and inadequate and does not cure your client's default.

In response to Dr. de la Torre's failure to appear, the Committee convened an executive session on September 19, 2024, and voted to report two resolutions to the Senate for further consideration. The first directs Senate Legal Counsel to bring a civil action to enforce the Committee's subpoena and the second authorizes the President of the Senate to certify a Committee report regarding the refusal of Dr. Ralph de la Torre to appear and testify before the Committee to the U.S. Attorney for the District of Columbia for criminal prosecution. Both resolutions were agreed to and favorably reported by the Committee.

Sincerely,

HON. BERNARD SANDERS,
CHAIRMAN.
HON. BILL CASSIDY, M.D.,
RANKING MEMBER,
U.S. SENATE COMMITTEE ON HEALTH,
EDUCATION, LABOR, AND PENSIONS.

[Whereupon, at 11:40 a.m., the hearing was adjourned.]

○

EXHIBIT E

G. L. c. 231, § 60L

actions against health care providers

Massachusetts General Laws Annotated
Part III. Courts, Judicial Officers and Proceedings in Civil Cases (Ch. 211-262)
Title II. Actions and Proceedings Therein (Ch. 223-236)
Chapter 231. Pleading and Practice (Refs & Annos)

M.G.L.A. 231 § 60L

§ 60L. Written notice requirement for actions against health care providers as defined in seventh paragraph of Sec. 60B; time for filing; exceptions; contents; provider's access to medical records; written response

Effective: November 4, 2012
Currentness

(a) Except as otherwise provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider 182 days written notice before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 182-day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182-day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against any health care provider involved in the claim.

(d) The 182 day notice of intent required in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice shall be sent as a potential party to the action before filing the complaint;

(e) The notice given to a health care provider under this section shall contain, but shall not be limited to, a statement including:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers that the claimant intends to notify under this section in relation to a claim.

(f) Not later than 56 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control and shall furnish a release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection shall not restrict a patient's right of access to the patient's medical records under any other law.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or the claimant's authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

(4) the manner in which the health care provider contends that the alleged negligence of the health care provider was or was not a proximate cause of the claimant's alleged injury or alleged damage.

(h) If the claimant does not receive the written response required under subsection (g) within the required 150-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150-day time period. If a provider fails to respond within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider shall accrue and be calculated from the date that the notice was filed rather than the date that the suit is filed. At any time before the expiration of the 150-day period, the claimant and the provider may agree to an extension of the 150-day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statutes of limitations or repose.

(j) A lawsuit against a health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, shall be exempt from compliance with this section.

(k) Nothing in this section shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

Credits

Added by St.2012, c. 224, § 221, eff. Nov. 4, 2012.

Notes of Decisions (4)

M.G.L.A. 231 § 60L, MA ST 231 § 60L
Current through Chapter 11 of the 2026 2nd Annual Session. Some sections may be more current; see credits for details.

End of Document

EXHIBIT F

G. L. c. 112, § 2

required professional malpractice liability insurance

KeyCite Yellow Flag
Proposed Legislation

Massachusetts General Laws Annotated
Part I. Administration of the Government (Ch. 1-182)
Title XVI. Public Health (Ch. 111-114)
Chapter 112. Registration of Certain Professions and Occupations (Refs & Annos)

M.G.L.A. 112 § 2

§ 2. Registration of physicians; alien applicants; examinations; renewal; required professional malpractice liability insurance; fees; continuing education relating to diagnosis, treatment and care of patients with cognitive impairments

Effective: April 8, 2025
Currentness

Applications for registration as qualified physicians, signed and sworn to by the applicants, shall be made upon blanks furnished by the board of registration in medicine, herein and in sections three to nine A, inclusive, called the board. Each applicant who shall furnish the board with satisfactory proof that he is eighteen years of age or over and of good moral character, that he has completed two years of premedical studies in a college or university, that he has attended courses of instruction for four years of not less than thirty-two school weeks in each year, or courses which in the opinion of the board are equivalent thereto, in one or more legally chartered medical schools, and that he has received the degree of doctor of medicine, or its equivalent, from a legally chartered medical school in the United States or commonwealth of Puerto Rico or Canada having the power to confer degrees in medicine, shall upon payment of a fee to be determined annually by the commissioner of administration under the provision of section three B of chapter seven, be examined, and, if found qualified by the board, be registered as a qualified physician and entitled to a certificate in testimony thereof, signed by the chairman and secretary. The board shall require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board. As used in this section, proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the "meaningful use" requirements, as set forth in 45 C.F.R. Part 170. An applicant who has received from a medical school, legally chartered in a sovereign state other than the United States, the commonwealth of Puerto Rico or Canada, a degree of doctor of medicine or its equivalent shall be required to

furnish to the board such documentary evidence as the board may require that his education is substantially the equivalent of that of graduates of medical schools in the United States and such other evidence as the board may require as to his qualifications to practice medicine, and shall, unless granted an exemption by the board, be required to present a Standard Certificate granted after examination by the Educational Council for Foreign Medical Graduates; provided, however, that an applicant who shall furnish the board with satisfactory proof that he is eighteen years of age or over and of good moral character, that he has completed two years of premedical studies in a college or university of the United States or Canada shall not be required to possess a certificate by the Educational Council for Foreign Medical Graduates and shall be admitted to the examination for licensure if he has studied medicine in a medical school outside the United States which is recognized by the World Health Organization, has completed all the formal requirements for the degree corresponding to doctor of medicine except internship and social service or internship or social service, has satisfactorily completed one academic year of supervised clinical training sponsored by an approved medical school in the United States or Canada, and has completed one year of graduate medical education in a program approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. If the board shall be satisfied as to his education and his qualifications, the board shall, upon payment of a fee determined under the aforementioned provision by the applicant, admit him to the examination for licensure.

An applicant failing to pass an examination satisfactory to the board shall be entitled to two reexaminations within two years at a meeting of the board called for the examination of applicants upon payment of a further fee determined under the aforementioned provision for each reexamination; but two such reexaminations shall exhaust his privilege under his original application.

The board may without examination grant certificates of registration as qualified physicians to such graduates of medical schools: (1) who shall furnish with their applications satisfactory proof that they have the qualifications required in the commonwealth to entitle them to be examined and have been licensed or registered upon a written examination in another state whose standards, in the opinion of the board, are equivalent to those in the commonwealth, or (2) who are diplomates of specialty boards recognized by the American Medical Association or the American Osteopathic Association; provided that any person who has previously attempted unsuccessfully to secure registration in the commonwealth shall be registered under the provisions of this paragraph without examination only at the discretion of the board. The fee for such registration without examination shall be determined under the aforementioned provision.

Notwithstanding any other provisions of this chapter the board may without examination grant a certificate of registration as a qualified physician to such person as shall furnish with his application

satisfactory evidence that he is: (1) a graduate of a Canadian medical school, or a medical school legally chartered in a sovereign state other than the United States or the commonwealth of Puerto Rico, and is licensed by the Medical Council of Canada and by a provincial licensing authority; or (2) is licensed in the commonwealth of Puerto Rico or in the province of Saskatchewan in Canada upon obtaining a grade of seventy-five per cent or better in the federation licensing examination of the federation of state medical boards of the United States. Any person granted a certificate of registration under the provisions of this paragraph shall pay a fee determined under the aforementioned chapter seven provision.

Notwithstanding any other provision of this chapter, the board may without examination grant a certificate of registration as a qualified physician to a person who is a graduate of a medical school which is legally chartered in a sovereign state other than the United States, the commonwealth of Puerto Rico or Canada, if such person furnishes proof satisfactory to the board that: (1) he has a full time academic appointment at a legally chartered medical school in the commonwealth; (2) he is qualified and competent in the field of medicine or surgery; and (3) he has been licensed or registered to practice medicine in such other state or country and has held a faculty appointment at a medical school legally chartered in such other state or country. Application for registration as a qualified physician, signed and sworn to by the applicant under the provisions of this section shall be made upon blanks furnished by the board. If satisfied as to the applicant's qualifications, and upon payment of a fee by such applicant, the board may issue to such applicant a certificate of registration as a qualified physician. Such certificate shall be restricted to the specialty in which he holds his academic appointment and shall be valid only so long as he holds a full time academic appointment. In addition to the requirements for renewal of certificates of registration under the provisions of section two, physicians registered under this section shall furnish with their renewal applications evidence satisfactory to the board that they continue to hold the faculty appointment required by this section. The board may adopt, amend and rescind such rules and regulations as it deems necessary to carry out the provisions of this section.

The board shall require that all physicians registered in the commonwealth renew their certificates of registration with the board at two year intervals. Effective nineteen hundred and eighty-seven, every physician registered in the commonwealth shall renew his or her certificate of registration with the board on or before his or her birthday in nineteen hundred and eighty-seven and in every second year thereafter; provided that if a birthday of any physician who shall be registered hereunder shall occur within three months after original registration, such person need not renew his or her registration until the birthday in the second year following the birthday aforesaid. For the purposes of this section, the birthday of a person born on February twenty-nine shall be deemed to be February twenty-eight. The renewal application shall be accompanied by a fee determined under the aforementioned provision and shall include the physician's name, license number, home

address, office address, specialties, the principal setting of their practice and whether they are an active or inactive practitioner.

The board is authorized to promulgate regulations requiring physicians to obtain professional malpractice liability insurance or a suitable bond or other indemnity against liability for professional malpractice in such amounts as may be determined by the board. The board shall participate in any national data reporting system which provides information on individual physicians.

The board shall require as a condition of granting or renewing a physician's certificate of registration, that the physician, who if he agrees to treat a beneficiary of health insurance under Title XVIII of the Social Security Act, shall also agree not to charge to or collect from such beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services. The board shall also require, as a condition of granting or renewing a physician's certificate of registration, that the physician apply to participate in the medical assistance program administered by the secretary of health and human services in accordance with chapter 118E and Title XIX of the Social Security Act and any federal demonstration or waiver relating to such medical assistance program for the limited purposes of ordering and referring services covered under such program, provided that regulations governing such limited participation are promulgated under said chapter 118E. A physician who chooses to participate in such medical assistance program as a provider of services shall be deemed to have fulfilled this requirement.

The board shall mail a renewal application to each registered physician sixty days prior to the renewal date. The certification of registration of any physician who does not file a completed renewal application together with the fee shall be automatically revoked, but shall be revived upon completion of the renewal process. The expenses and compensation of the board of registration and discipline in medicine[1] shall be paid by the commonwealth, but said expenses and compensations shall not be in excess of the amounts received by the commonwealth for certificates of renewal or any registration fees under this section.

The board shall require that any continuing education requirements necessary for the renewal of a physician's certificate of registration include the 1-time completion of a course of training and education on the diagnosis, treatment and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia; provided, however, that this course requirement shall only apply to physicians who serve adult populations.

Credits

Amended by St.1933, c. 171, § 1; St.1936, c. 247, §§ 1, 2; St.1938, c. 210; St.1939, c. 415, § 1; St.1939, c. 451, § 37; St.1941, c. 722, § 9; St.1945, c. 396, §§ 1, 2; St.1946, c. 365; St.1948, c. 28; St.1948, c. 413; St.1952, c. 585, § 21; St.1954, c. 519, § 1; St.1955, c. 622; St.1957, c. 329; St.1959, c. 344, § 1; St.1960, c. 177; St.1960, c. 367; St.1966, c. 299; St.1969, c. 426, §§ 1, 2; St.1970, c. 540; St.1971, c. 662; St.1972, c. 372; St.1973, c. 312; St.1973, c. 925, § 16; St.1974, c. 395; St.1974, c. 396; St.1974, c. 723, §§ 1 to 3; St.1975, c. 138; St.1975, c. 362, § 2; St.1979, c. 58, § 2; St.1980, c. 572, §§ 98 to 103; St.1985, c. 475; St.1986, c. 351, §§ 11, 12; St.1986, c. 673; St.1993, c. 495, § 31; St.2012, c. 118, § 19, eff. June 19, 2012; St.2012, c. 224, § 108, eff. Jan. 1, 2015; St.2018, c. 220, § 3, eff. Nov. 7, 2018; St.2024, c. 343, § 71, eff. April 8, 2025.

Notes of Decisions (25)

Footnotes

1 So in enrolled bill; probably should read “board of registration in medicine”.

M.G.L.A. 112 § 2, MA ST 112 § 2

Current through Chapter 11 of the 2026 2nd Annual Session. Some sections may be more current; see credits for details.

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EXHIBIT G

Lifespan Motion

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re: STEWARD HEALTH CARE SYSTEM LLC, *et al.*, Debtors.[1]	Chapter 11 Case No. 24-90213 (CML) (Jointly Administered)

LIFESPAN OF MASSACHUSETTS, INC.'S
MOTION FOR RELIEF FROM THE AUTOMATIC STAY
TO ALLOW FOR THE SETOFF OF MUTUAL OBLIGATIONS
IF AND TO THE EXTENT THAT RECOUPMENT IS NOT AVAILABLE

THIS IS A MOTION FOR RELIEF FROM THE AUTOMATIC STAY. IF IT IS GRANTED, THE MOVANT MAY ACT OUTSIDE OF THE BANKRUPTCY PROCESS. IF YOU DO NOT WANT THE STAY LIFTED, IMMEDIATELY CONTACT THE MOVING PARTY TO SETTLE. IF YOU CANNOT SETTLE, YOU MUST FILE A RESPONSE AND SEND A COPY TO THE MOVING PARTY AT LEAST 7 DAYS BEFORE THE HEARING. IF YOU CANNOT SETTLE, YOU MUST ATTEND THE HEARING. EVIDENCE MAY BE OFFERED AT THE HEARING AND THE COURT MAY RULE. REPRESENTED PARTIES SHOULD ACT THROUGH THEIR ATTORNEY. THERE WILL BE A HEARING ON THIS MATTER ON MAY 14, 2026 AT 1:00 PM IN COURTROOM 402, 515 RUSK, HOUSTON, TX 77002.

Lifespan of Massachusetts, Inc. ("Lifespan" or "Buyer")[2] moves for the entry of an order, substantially in the form attached hereto, granting relief from the automatic stay to allow Lifespan to set off mutual obligations if and to the extent that recoupment is not available.

PRELIMINARY STATEMENT

1. In the fall of 2024, as the Debtors' hospitals faced imminent closure, Lifespan stepped in as the winning bidder for Saint Anne's Hospital and Morton Hospital (the "Hospitals"),

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

[2] Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to them in the APA or the Sale Order.

ensuring that critical healthcare services would continue for the communities those Hospitals serve. In doing so, Lifespan saved the Hospitals from shutting their doors, preserving thousands of jobs and ensuring uninterrupted access to care for the surrounding communities. Lifespan's purchase of the Hospitals also saved the Debtors millions of dollars in expenses associated with the potential closure of the Hospitals.

2. The APA (defined below) that Lifespan executed with the Debtors contained a number of bargained-for protections essential to the transaction – including the price paid for the Hospitals. Among those essential terms was the Debtors' obligation to maintain medical malpractice tail insurance for the Hospitals and the related physicians — a commitment that was critical to recruiting and retaining the physicians necessary to operate the Hospitals. The Debtors failed to honor that commitment. As a result, Lifespan has already been forced to allocate over $5.9 million to provide adequate malpractice insurance coverage for its physicians, as set forth herein and in the *Lifespan of Massachusetts, Inc.'s Motion for Allowance and Payment of Administrative Expense* ((Docket No. 3818), the "Administrative Claim").

3. The Debtors likewise failed to honor their rental payment obligations under the Bill of Sale, leaving $102,249.99 in outstanding payments owed to Lifespan. This is in addition to the Administrative Claim that Lifespan has arising under the APA due to the Debtors' inability to meet their obligations that were key components of Lifespan's agreement to buy the Hospitals.

4. Lifespan now finds itself in the untenable position of absorbing millions of dollars in additional losses caused by the Debtors' serial breaches, at the same time the Debtors are seeking to collect Pre-Closing Obligation payments from Lifespan. The equitable resolution is straightforward: the mutual obligations between Lifespan and the Debtors should be set off against one another. Lifespan has the right to reconcile the amounts owed between Lifespan and the

Debtors either through recoupment or, alternatively, setoff, which would efficiently resolve the debts between the parties. Permitting setoff avoids the absurdity of requiring Lifespan to pay the Debtors while waiting, perhaps in vain, for the Debtors to satisfy their own substantial obligations to Lifespan. Accordingly, Lifespan respectfully requests that this Court enter an order granting relief from the automatic stay to permit the exercise of its recoupment and setoff rights.

JURISDICTION AND VENUE

5. The United States Bankruptcy Court for the Southern District of Texas (the "Court") has jurisdiction over this matter pursuant to 28 U.S.C. §§ 157 and 1334. This is a core proceeding pursuant to 28 U.S.C. § 157, and this Court may enter a final order consistent with Article III of the United States Constitution. Venue is proper pursuant to 28 U.S.C. §§ 1408 and 1409.

6. The legal predicates for the relief requested in this Motion are sections 362(d)(1), 553(a) of title 11 of the United States Code, Rule 4001 of the Federal Rules of Bankruptcy Procedure, and Rule 4001-1 of the Bankruptcy Local Rules for the Southern District of Texas, and the Procedures for Complex Cases in the Southern District of Texas.

BACKGROUND

A. Case Background

7. On May 6, 2024 (the "Petition Date"), Steward Health Care Systems LLC and its affiliated debtors each filed a voluntary petition for relief under Chapter 11 of the Bankruptcy Code in this Court.

8. On June 3, 2024, this Court entered the *Order (I) Approving (A) Global Bidding Procedures for Sales of the Debtors' Assets, (B) Form and Manner of Notice of Sales, Auctions, and Sale Hearings, and (C) Assumption and Assignment Procedures and Form and Manner of Notice of Assumption and Assignment; (II) Authorizing Designation of Stalking Horse Bidders; (III) Scheduling Auctions and Sale Hearings; and (IV) Granting Related Relief* (Docket No. 626)

(the "Bidding Procedures Order") approving global bidding procedures in connection with the sale of substantially all of the Debtors' assets, including Holy Family Methuen Hospital, Holy Family Haverhill Hospital, Saint Anne's Hospital, Morton Hospital, St. Elizabeth's Medical Center, and Good Samaritan Medical Center, and granting other related relief.

9. On August 29, 2024, the Debtors filed the *Notice of (I) Designation of Successful Bids; (II) Proposed Sale Order; (III) Scheduling of Sale Hearing With Respect to (A) Holy Family Methuen Hospital, (B) Holy Family Haverhill Hospital, (C) Saint Anne's Hospital, and (D) Morton's Hospital; and (IV) Reservation of Rights to Seek Approval of Sale of St. Elizabeth's Medical Center and Good Samaritan Medical Center at Sale Hearing* (Docket No. 2242) (the "Notice of Winning Bidder"). A copy of the final and executed asset purchase agreement for Saint Anne's Hospital and Morton Hospital was attached as Exhibit "1" to Exhibit "C" to the Notice of Winning Bidder (the "APA").[3]

10. On September 13, 2024, this Court entered the *Order (I) Authorizing and Approving (A) the Sale of Saint Anne's Hospital and Morton Hospital Free and Clear of Liens, Claims, Encumbrances, and Interests and (B) the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (II) Granting Related Relief* (Docket No. 2520) (as supplemented on September 30, 2024 (Docket No. 2721), the "Sale Order"). The Sale Order, among other things, approved the sale of Saint Anne's Hospital and Morton Hospital (the "Hospitals") to Lifespan, as set forth in and pursuant to the APA.

11. The Debtors represented to Lifespan via insurance certificates that they would maintain medical malpractice tail insurance (the "TRACO Insurance") through a non-Debtor

[3] Because the documents referenced in this Motion are voluminous in nature, they are not attached hereto, but will be made available upon request of a party-in-interest.

subsidiary, TRACO International Group S. DE R.L. ("TRACO"). *See* APA Exhibit U. According to the Debtors' representations, the TRACO Insurance would provide coverage for incidents that occurred during the Debtors' physicians' employment with the Debtors, regardless of when reported. Pursuant to the terms of Sections 6.16 and 7.15 of the APA, the Debtors were responsible for maintaining tail insurance coverage through May 15, 2027. The Debtors' commitment to provide TRACO Insurance was a key term of the APA, as such insurance was necessary to recruit and retain physicians, who are essential to the hospital's operations. *See* ¶ 3, Almeida Declaration.

12. In late November 2024, post-closing, Lifespan learned that TRACO was severely underfunded,[4] and that, as a result, the Debtors' representations regarding the TRACO Insurance coverage were false and insurance coverage would not actually be available to insured providers after the Closing Date.

13. As a direct result of the Debtors' failure to satisfy their obligations under Sections 6.16 and 7.15 of the APA, Lifespan was forced to provide prior acts insurance coverage as a secondary malpractice insurance through their captive insurance program for physicians that accepted employment with Lifespan. To date, Lifespan has been forced to fund $5 million in captive insurance and pay an additional $935,267.84 to secure a $5 million of excess malpractice insurance, which amount is required to ensure full coverage for its employees, as further detailed in the *Declaration of Richard J. Almeida* (the "Almeida Declaration"), filed contemporaneously herewith. This amount, which should have been paid by the Debtors, is subject to a reduction of the Purchase Price under Section 1.6(vi) of the APA because it relates to an amount the Buyers incurred to pay costs that the Debtors are obligated to cover under the terms of the APA. Indeed,

[4] *See* Jessica Bartlett et al., *Steward Health Care raided the coffers of its in-house malpractice insurer, leaving claimants, doctors in limbo,* BOSTON GLOBE (Nov. 25, 2024), https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/.

the Purchase Price offered by Lifespan would have been proportionally lower had such insurance not been included in the Sale.

14. On January 27, 2025, Lifespan filed the Administrative Claim. The Administrative Claim accounts for both the Debtors' failure to perform their obligations under the APA and provide adequate insurance coverage, requesting $5,271,000.00 in connection with the foregoing. After filing the Administrative Claim, on August 20, 2025, Lifespan purchased $5 million in excess insurance coverage for a premium of $935,267.84. The excess insurance covers amounts over $5 million, reducing Lifespan's captive insurance obligations by $271,000.00. This leaves the total insurance costs incurred by Lifespan at $5,935,267.94.

15. Under the June 25, 2025 Side Letter, attached hereto as **Exhibit A**, the Debtors agreed to set-off any outstanding rental payments due to the Buyer against the amounts owed under the purchase price from the APA pursuant to the Bill of Sale. On July 23, 2025, Lifespan wrote to the Debtors informing them of $102,249.99 in outstanding rental payments due for docking at the Hawthorn site. The Debtors responded on August 7, 2025 stating that they would not set-off the outstanding rental payments which had accumulated over several months predating the Side Letter. To date, the Debtors still owe Lifespan $102,249.99 in outstanding rental payments pursuant to their obligations and commitments under the Bill of Sale.

16. On March 11, 2025, this Court entered the *Order (I) Authorizing and Approving (A) Sale of Transition Services Agreement Assets Free and Clear of All Interests and Encumbrances to Golden Sun TSA Services, LLC, an Affiliate of Quorum Health Corporation, (B) Assumption and Assignment of Certain Executory Contracts and Unexpired Leases, and (C) Related Settlements; and (II) Granting Related Relief* ((Docket No. 4192), the "TSA Sale Order").

17. The TSA Sale Order released certain Lifespan administrative claims against the Debtors outside of the Debtors' "obligations under the APA, Settlement, Vendor Fund Escrow Agreement, and any other transactions entered into in connection with the Settlement," and specifically further provided that the release would not apply to any of the Debtors' obligations "to the Buyer under the APA, the Settlement, the Vendor Fund Escrow Agreement, or any other transaction or agreement entered into in connection with the Sale Transaction." *See* TSA Sale Order at p.20.

ARGUMENT

A. Lifespan's Outstanding Administrative Claim and Unpaid Rent from the Bill of Sale May be Recouped Without Relief from the Automatic Stay

18. The doctrine of recoupment is an equitable remedy that permits a party to reduce amounts owed to a debtor against amounts owed by a debtor that arise out of the "same transaction." *See Holford v. Powers (In re Holford)*, 896 F.2d 176, 179 (5th Cir.1990). A party seeking recoupment is not subject to the automatic stay. *See Kosadnar v. Metro. Life Ins. Co. (In re Kosadnar)*, 157 F.3d 1011, 1016 (5th Cir. 1998) ("[p]ost-petition recoupment does not violate the automatic stay").

19. Courts evaluate whether it is equitable for the debtor to enjoy the benefits of a transaction without meeting their obligations thereunder. "Transaction" is defined broadly by the Fifth Circuit, which reviews the facts and equities at hand holistically. *See Kadonsky v. United States*, 216 F.3d 499, 507 (5th Cir. 2000) (citing *Kosadnar*, 157 F.3d at 1015) ("There is no general standard governing whether events are part of the same or different transactions. Given the equitable nature of the recoupment doctrine, courts have refrained from precisely defining the same-transaction standard, focusing instead on the facts and the equities of each case."); *In re Eggers*, 432 B.R. 577, 582 (Bankr. W.D. Tex. 2010) ("The Fifth Circuit has purposely been

somewhat vague on the contours of recoupment, allowing the trial courts to determine whether recoupment applies based upon the facts and circumstances of the case.") *In re Eggers*, 432 B.R. 577, 582 (Bankr. W.D. Tex. 2010).

20. Section 12.2 of the APA states that Delaware law governs all disputes or claims arising out of or relating to the APA. *See* APA p.75. Under Delaware law, "all writings that are part of the same transaction are interpreted together." Restatement (Second) of Contracts § 202(2).

21. The Debtor's failure to satisfy their obligations under Sections 6.16 and 7.15 of the APA, and decision not to recognize rent payments from the Bill of Sale all arise under the same transaction. Due to the Debtors' failure to satisfy their obligations under Sections 6.16 and 7.15 of the APA, Lifespan was forced to allocate a total of $5,935,267.84 for adequate malpractice insurance. In addition, Debtors did not recognize the rent payments due and owing under the Bill of Sale in the amount of $102,249.99.

22. On March 11, 2026, the Debtors requested that Lifespan remit funds they were holding in trust as part of the Pre-Closing Obligations under Section 17(d) of the Sale Order. The Sale Order expressly authorizes the APA executed between Lifespan and the Debtors. There would be no obligations under the Sale Order if the APA between the Debtors and Buyer was never executed.

23. Lifespan's Pre-Closing Obligations are therefore part of the same transaction as the Administrative Claim they have asserted against the Debtor for the failure to provide adequate insurance under the APA and recognize outstanding rent payments under the Bill of Sale. As such, these amounts are recoupable. It would be inequitable for the Debtors to enjoy the benefits of Pre-Closing Obligation payments without meeting its mandated APA obligations.

24. Moreover, Lifespan and Steward explicitly agreed the APA and Bill of Sale are all integrated into a single entire agreement under the APA: "This Agreement (inclusive of Exhibits and Schedules), together with the other Transaction Documents and the Confidentiality Agreement and any other agreement which specifically references this Section 12.14, represent the entire agreement[.]" *See* APA Section 12.14 p.77.[5] Because the APA and Bill of Sale are a single integrated agreement under Delaware law they represent a single transaction under both the facts and equities of this case.

25. The amounts due thereunder are subject to recoupment by Lifespan because the Debtors have refused to compensate Lifespan for their failure to perform obligations under the APA as preserved by the TSA Sale Order.

B. If Recoupment Is Not Applicable, Lifespan has a Right to Setoff Mutual Postpetition Obligations with Steward

26. Notwithstanding that Lifespan is entitled to recoupment, in the alternative, the Court may still permit Lifespan to recover through setoff.

27. Setoff is available where there are mutual obligations between a debtor and a creditor (*i.e.*, both obligations are held by the same parties). *See Braniff Airways, Inc. v. Exxon Co., U.S.A.*, 814 F.2d 1030, 1036 (5th Cir. 1987). "The right of setoff (also called 'offset') allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding 'the absurdity of making A pay B when B owes A.'" *Citizens Bank v. Strumpf*, 516 U.S. 16, 18 (1995). Section 553(a) of the Bankruptcy Code recognizes and preserves rights of setoff where four conditions exist: (1) the creditor holds a claim that arose before the commencement of the

[5] The Transaction Documents include the Bill of Sale under the APA. ""Transaction Documents" means this Agreement, the Existing MPT Lease Termination, the Bill of Sale, the Assignment and Assumption Agreement, the Lease Assignments, the MPT Real Property Purchase Agreement, the Power of Attorney, the Intellectual Property Agreement, the Transition Services Agreement, the Professional Services Agreement, and the Leaseback Agreement, including, in each case, all schedules, exhibits, and other attachments thereto." *See* APA Annex A.

case; (2) the creditor owes a pre-petition debt to the debtor; (3) the claim and the debt are mutual; and (4) the claim and the debt are each valid and enforceable. 11 U.S.C. § 553(a).

28. Although section 553 only contemplates setoff rights in the context of prepetition debts, courts have repeatedly recognized the right to setoff applies to mutual, postpetition obligations. *See In re Quantum Foods, LLC*, 554 B.R. 729, 734 (Bankr. D. Del. 2016) (collecting cases from the Third, Fifth, and Tenth Circuits and several bankruptcy courts allowing setoff of mutual, postpetition obligations). "[T]he general rule is that, subject to the restrictions imposed by section 362, a postpetition claim may be offset against a postpetition debt so long as the claim and debt constitute valid, mutual obligations." 5 Collier on Bankruptcy P 553.03 (16th 2026). *See also In re Hill*, 19 B.R. 375, 380 (Bankr. N.D. Tex. 1982) (acknowledging postpetition obligation could be set off against a postpetition claim). These cases demonstrate that setoff is available when "the opposing obligations arise on the same side of the ... bankruptcy petition date." *See Id*. (quoting *Pa. State Employees' Ret. Sys. v. Thomas (In re Thomas),* 529 B.R. 628, 637 n. 2 (Bankr. W.D. Pa. 2015)).

29. Lifespan's Administrative Claim and the unpaid rent under the Bill of Sale and the Debtors' Pre-Closing Obligations asserted against the Debtors both arose post-petition and represent mutual obligations between the parties. Because Lifespan can collect against the Debtor entities on a joint and several basis mutuality exists between the parties.

30. Consequently, all of the elements of setoff are met and Lifespan should be permitted to setoff the amounts due under the Administrative Claim in addition to unpaid rent under the Bill of Sale against the Pre-Closing Obligations that Lifespan owes to the Debtors.

C. Relief from the Automatic Stay Is Appropriate to Allow Lifespan to Exercise Its Setoff Rights

31. Bankruptcy Code section 362(a)(7) prevents execution of setoff rights absent relief from the automatic stay. *See* 11 U.S.C. § 362(a)(7) ("(a) . . . a petition . . . operates as a stay, applicable to all entities, of— . . . (7) the setoff of any debt owing to the debtor that arose before the commencement of the case under this title against any claim against the debtor . . . ."). However, pursuant to section 362(d), a bankruptcy court may grant relief from stay when a creditor demonstrates adequate grounds for such relief. *See* 11 U.S.C. § 362(d)(1). Lifespan seeks to modify the automatic stay to the extent necessary to assert and setoff set forth in this Motion.

32. A right to setoff marks a *prima facie* showing of "cause" for stay relief under section 362(d) of the Bankruptcy Code. *See In re Ealy*, 392 B.R. 408, 414 (Bankr. E.D. Ark. 2008) (citing *In re Nuclear Imaging Sys.*, Inc., 260 B.R. 724, 730 (Bankr. E.D. Pa. 2000); *In re Orlinski*, 140 B.R. 600, 603 (Bankr. S.D. Ga.1991); *In re Coleman*, 52 B.R. 1, 3 (Bankr. S.D. Ohio 1985); *i, Inc.*, 47 B.R. 299, 303 (Bankr. D.N.J. 1985)); *See also United States v. Gould* (In re Gould), 401 B.R. 415, 426 (9th Cir. B.A.P. 2009)). Once a prima facie case is established, the burden shifts to the party opposing relief. *In re Ealy*, 392 B.R. at 414 (internal citations omitted).

33. Cause exists to grant Lifespan stay relief to set off the amounts due under its Administrative Claim and the unpaid rent under the Bill of Sale against the Pre-Closing Obligations due to Debtors. Lifespan should not be required to pay the Debtors when the Debtors owe significant amounts to Lifespan. Moreover, allowing setoff would also result in the resolution of a significant amount of administrative expense claims against the Debtors.

D. Rule 4001(a)(3) Waiver

34. Lifespan also seeks a waiver of the 14-day stay of the effectiveness of the order terminating the stay pursuant to Bankruptcy Rule 4001(a)(3). The facts and circumstances here

warrant this waiver. The amounts owed to/due from Lifespan are not disputed, the Lifespan has acted in good faith regarding its exercise of setoff/recoupment rights, and the obligations due to Lifespan reflect priority administrative claims. The prompt exercise of recoupment/setoff rights is warranted.

RESERVATION OF RIGHTS

35. The Buyer reserves all rights and waives none with respect to any amounts owed to the Buyer and its affiliates by the Seller and its affiliates under the APA or any other agreement, whether or not related to or incorporated into the APA. For the avoidance of doubt, the Buyer reserves all rights and waives none with respect to any amounts owed to the Buyer and its affiliates by the Seller and its affiliates under that certain Transition Services Agreement, dated as of October 1, 2024, by and among Steward Health Care System, LLC and Lifespan of Massachusetts, Inc. and its affiliates.

[*Remainder of Page Intentionally Left Blank*]

CONCLUSION

WHEREFORE, Lifespan respectfully requests that the Court enter an order, substantially in the form attached hereto, granting relief from the automatic stay to allow Lifespan to set off mutual obligations if and to the extent recoupment is not available.

Dated: April 14, 2026

Respectfully submitted,

ROPES & GRAY LLP

/s/ Cristine Pirro Schwarzman

Cristine Pirro Schwarzman (admitted *pro hac vice*)
1211 Avenue of the Americas
New York, New York 10036
Telephone: (212) 596-9000
Facsimile: (212) 596-9090
E-mail: cristine.schwarzman@ropesgray.com

-and-

William Roberts (admitted *pro hac vice*)
Prudential Tower, 800 Boylston Street
Boston, Massachusetts 02199-3600
Telephone: (617) 951-7000
Facsimile: (617) 951-7050
E-mail: william.roberts@ropesgray.com

Counsel to Lifespan of Massachusetts, Inc.

CERTIFICATE OF SERVICE

I certify that on April 14, 2026, I caused a copy of the foregoing document to be served by the Electronic Case Filing System for the United States Bankruptcy Court for the Southern District of Texas.

/s/ Cristine Pirro Schwarzman
Cristine Pirro Schwarzman

EXHIBIT A

Side Letter

June 25, 2025

Steward PET Imaging LLC
c/o Steward Healthcare System LLC
1900 N. Pearl Street, #2400
Dallas, Texas 75201

Re: Purchase Price Consideration Setoff Relating to Steward PET Imaging Asset Sale

To whom it may concern:

Reference is hereby made to that certain Bill of Sale, Assignment and Assumption Agreement by and between Lifespan of Massachusetts – Taunton, Inc., a Massachusetts nonprofit corporation ("Buyer"), and Steward PET Imaging, LLC, a Massachusetts limited liability company ("Seller"), dated as of even date herewith (the "Purchase Agreement"). All defined terms used but not defined herein shall have the meaning ascribed to them in the Purchase Agreement.

This letter shall serve as acknowledgment by Lifespan Corporation d/b/a Brown University Health ("Brown") of the agreement between Buyer, a controlled affiliate of Brown, and Seller that the Cash Consideration paid by Buyer to Seller in connection with Buyer's acquisition of the Purchased Assets includes a consideration set-off in the amount of the outstanding Saint Anne's Hospital rent due and payable by Seller to Buyer as of the Effective Time, the amount of such outstanding rent and consideration set-off being in the amount of $12,944.49 (the "Set-off Amount"). With it being hereby acknowledged that the Set-Off Amount is sufficient consideration therefore, Brown, on behalf of itself and all of its controlled affiliates, including but not limited to Buyer and Lifespan of Massachusetts – Fall River, Inc. (collectively, the "Brown Organizations"), hereby releases Buyer from any and all claims relating to rent payment or similar obligations payable or otherwise owing from Seller to any of the Brown Organizations as of the Effective Time.

Very truly yours,

BROWN UNIVERSITY HEALTH,
on behalf of itself and all other Brown Organizations

By: Peter K. Markell
Peter K. Markell (Jun 27, 2025 12:08 EDT)

Name: Peter Markell

Title: Executive Vice President and Chief Financial Officer, Brown University Health

ACTIVE_154695706_2_Side Letter - Rent Offset (Steward PET) (Execution Version)

Final Audit Report 2025-06-27

Created:	2025-06-27
By:	Laurie Frye (laurie.frye@lifespan.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAS8PYAaF_zZydJfyP5YamkGP5TLjfRBDL

"ACTIVE_154695706_2_Side Letter - Rent Offset (Steward PET) (Execution Version)" History

Document created by Laurie Frye (laurie.frye@lifespan.org)
2025-06-27 - 1:44:09 PM GMT

Document emailed to pmarkell@brownhealth.org for signature
2025-06-27 - 1:44:12 PM GMT

Email viewed by pmarkell@brownhealth.org
2025-06-27 - 4:02:47 PM GMT

Signer pmarkell@brownhealth.org entered name at signing as Peter K. Markell
2025-06-27 - 4:07:59 PM GMT

Document e-signed by Peter K. Markell (pmarkell@brownhealth.org)
Signature Date: 2025-06-27 - 4:08:01 PM GMT - Time Source: server

Agreement completed.
2025-06-27 - 4:08:01 PM GMT

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	Chapter 11
	Case No. 24-90213 (CML)
Debtors.[1]	(Jointly Administered)

ORDER GRANTING LIFESPAN OF MASSACHUSETTS, INC.'S MOTION FOR RELIEF FROM THE AUTOMATIC STAY TO ALLOW FOR THE SETOFF OF MUTUAL OBLIGATIONS IF AND TO THE EXTENT THAT RECOUPMENT IS NOT AVAILABLE

[Relates to Docket No. ___]

Upon consideration of *Lifespan of Massachusetts, Inc.*'s ("Lifespan") *Motion for Relief from the Automatic Stay to Allow for the Setoff of Mutual Obligations if and to the Extent Recoupment is not Available Allowance and Payment of Administrative Expense Claim* (the "Motion")[2] for entry of an order (this "Order") (i) granting relief from the automatic stay to allow Lifespan to set off mutual obligations if and to the extent that recoupment is not available, and (ii) granting such other and further relief that is just and proper, all as more fully set forth in the Motion; and this Court having jurisdiction over this matter pursuant to 28 U.S.C. § 1334; and this Court having found that this is a core proceeding pursuant to 28 U.S.C.§ 157(b), and that this Court may enter a final order consistent with Article III of the United States Constitution; and this Court having found that venue of this proceeding and the Motion in this district is proper

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

[2] Capitalized terms used but not defined herein shall have the meanings ascribed to them in the Motion.

pursuant to 28 U.S.C. §§ 1408 and 1409; and this Court having found that notice of the Motion and opportunity for a hearing on the Motion were appropriate and no other notice need be provided; and this Court having reviewed the Motion and having heard the statements in support of the relief requested therein at a hearing (if any) before this Court; and this Court having determined that the legal and factual bases set forth in the Motion establish just cause for the relief granted herein; and upon all of the proceedings had before this Court; and after due deliberation and sufficient cause appearing therefor,

IT IS HEREBY ORDERED THAT:

1. The automatic stay shall be modified, effective as of the entry of this Order, to permit Lifespan to set off:

(i) $5,935,267.84 allocated in malpractice insurance provided post-petition, and

(ii) $102,249.99 in outstanding rental payments owed by the Debtors to lifespan against all claims payments and/or reimbursement obligations owed to the Debtors.

2. Notwithstanding the provisions of Bankruptcy Rule 4001(a)(3), this Order shall be immediately effective and enforceable upon its entry.

3. The Court shall retain exclusive jurisdiction with respect to all matters arising from or related to the implementation, interpretation, and enforcement of this Order.

Dated:

HONORABLE CHRISTOPHER M. LOPEZ

EXHIBIT H

Physician Affidavits

Affidavit of Tricia Allman

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
	x	(Jointly Administered)
Debtors.	x	

AFFIDAVIT OF TRICIA ALLMAN, M.D.

I, Tricia Allman, M.D., hereby depose and state as follows:

1. I am a physician licensed to practice medicine and formerly practiced as a primary care physician affiliated with Steward Health Care System, LLC ("Steward"). I retired from practice in or around the spring of 2023.

2. In or around 2025, I was notified that I had been named as a defendant in a medical malpractice action arising from care provided during my prior Steward-affiliated employment.

3. Following notice of the claim, I learned that TRACO was not honoring obligations relating to malpractice coverage and litigation defense arising from Steward's bankruptcy proceedings and the resulting financial deterioration of Steward's insurance and risk management structure.

4. As a result, I have personally incurred substantial expenses in an effort to protect myself from uninsured professional liability exposure, including approximately $55,000 for tail malpractice coverage and legal retainers associated with the pending litigation.

5. I have also been advised that, if the matter proceeds through trial, the costs associated with defending the case could increase by an additional approximately $50,000 to $75,000, exclusive of any potential personal liability associated with an adverse judgment or settlement.

6. Although I was ultimately able to secure legal representation, the process was initially difficult because multiple malpractice defense attorneys I contacted expressed reluctance to undertake representation in matters involving TRACO due to prior experiences involving unpaid legal fees and unpaid malpractice obligations.

7. The uncertainty surrounding the availability of malpractice coverage and defense protection following Steward's bankruptcy proceedings has caused substantial stress and concern for both me and my family.

8. I submit this affidavit voluntarily and based upon my personal knowledge.

Signed under the pains and penalties of perjury this 14 day of May 2026.

Tricia Allman, M.D.

Affidavit of Erik Deede, M.D.

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
	x	
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
	x	
	x	(Jointly Administered)
Debtors.	x	

AFFIDAVIT OF ERIK DEEDE, M.D.

1. I am a physician in good standing and licensed to practice medicine in the Commonwealth of Massachusetts since 2003;

2. Over the course of my career, I provided emergency medical services at multiple Steward Health Care facilities, including Nashoba Valley Medical Center, Holy Family Hospital, and St. Elizabeth's Medical Center;

3. In about 2020, a medical malpractice lawsuit was filed against me arising from care rendered during my employment at a Steward facility in 2017. At that time, Steward provided me with insurance funds to defend the lawsuit, and counsel was retained and performed work on my behalf to defend the lawsuit;

4. While relatively little activity occurred in connection with the lawsuit for several years, in about February 2026, after Steward filed these bankruptcy proceedings, I was informed that insurance funds were no longer available to continue to pay for my legal defense. As a result, I have been forced to spend personal funds by paying out of pocket in order for attorney's fees and associated defense costs to protect my interests in the litigation;

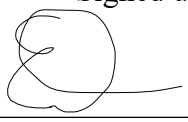
5. I have also been informed that no other malpractice coverage exists for any other claims that may arise from care I rendered during my employment at Steward-owned hospitals, including Nashoba Valley Medical Center, Holy Family Hospital, and St. Elizabeth's Medical Center. As a result, I am exposed to personal liability for future any claims that may arise from care rendered during my employment at those facilities;

6. Although the lawsuit was dismissed on procedural grounds in about November 2025, I continue to maintain counsel on retainer because of the possibility that the matter may later be reactivated or refiled;

7. As a direct result of the ongoing uncertainty surrounding the availability of malpractice coverage and defense funding, I am presently considering spending tens of thousands of dollars of my own personal funds to attempt to secure tail malpractice coverage in order to protect myself from future uninsured liability exposure;

8. I am experiencing substantial financial and professional hardship as a direct result of the risk of personal exposure for an adverse judgment and the prospect of personally funding legal defense costs and tail insurance coverage due to the absence of stable malpractice coverage following Steward's bankruptcy.

Signed under the pains and penalties of perjury this 13 day of May, 2026.



Erik Deede, M.D.

Affidavit of Jairam R. Eswara, M.D.

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
	x	(Jointly Administered)
Debtors.	x	

AFFIDAVIT OF JAIRAM R. ESWARA, M.D.

I, Jairam R. Eswara, M.D., hereby depose and state as follows:

1. I am a physician licensed to practice medicine and am currently the Chair of Urology at Tufts University School of Medicine and Tufts Medical Center.

2. Prior to leaving my employment affiliated with Steward Health Care System, LLC ("Steward") in or around April 2025, I was led to believe that I would continue to have professional liability protection, including tail malpractice coverage, following my departure from Steward.

3. After leaving Steward, I subsequently learned that I did not, in fact, have the tail malpractice coverage I believed would be available to me and that I would instead be required to independently obtain and purchase my own tail coverage at substantial personal expense.

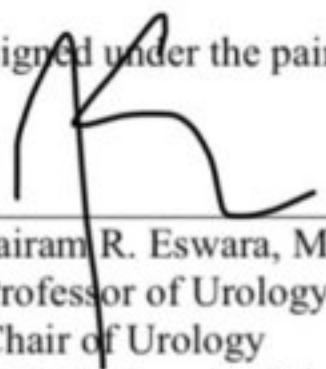
4. Before I had the opportunity to secure that coverage, I was named as a defendant in a medical malpractice lawsuit in or around May 2025.

5. As a result, I have been placed in the position of simultaneously having to obtain my own legal counsel to defend the litigation while also purchasing extremely expensive tail malpractice coverage in an effort to protect myself from additional professional exposure.

6. The uncertainty and instability surrounding the availability and continuation of malpractice coverage following Steward's bankruptcy proceedings has created substantial professional stress and ongoing concern regarding my personal exposure in litigation arising from care provided during my prior Steward-affiliated employment.

7. I submit this affidavit voluntarily and based upon my personal knowledge.

Signed under the pains and penalties of perjury this 14 day of May 2026.



Jairam R. Eswara, M.D. FACS
Professor of Urology
Chair of Urology
Tufts University School of Medicine
Tufts Medical Center

Affidavit of Peter L. Rees, M.D.

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
	x	
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
	x	
	x	(Jointly Administered)
Debtors.	x	

AFFIDAVIT OF PETER L. REES, M.D.

1. I am a physician in good standing and licensed to practice medicine in the Commonwealth of Massachusetts. I am a primary care physician and previously practiced medicine in Haverhill, Massachusetts;

2. I was formerly employed providing medical services through Steward Health Care System, LLC's ("Steward") primary care practice network prior to and during Steward's bankruptcy proceedings in 2024. Prior to Steward's bankruptcy, I received medical malpractice liability insurance coverage under Steward's insurance and risk management structure;

3. Following Steward's bankruptcy filing, the primary care practices where I practiced were purchased by an entity based in Tennessee presently operating as Revere Medical Group. The transaction involved Steward affiliated primary care practices only and did not include Steward hospitals or specialist practices;

4. Following the transition of operations to Revere Medical Group, physicians continuing employment with the new entity were informed that malpractice tail coverage would be arranged prospectively for new employment. However, physicians already involved in pending malpractice litigation arising from care rendered during prior Steward employment were left without meaningful protection or support relating to those claims;

5. I am presently involved in active malpractice litigation arising from medical care rendered during my Steward employment. Because of the continuing uncertainty surrounding Steward's insurance and risk management structure and the lack of available defense funding, I have been required to personally retain and fund defense counsel at my own expense;

6. To my knowledge, Steward and Traco are not presently funding my defense counsel, litigation expenses, or expert witness costs associated with defending these claims. In addition, I do not know whether any insurance proceeds or bankruptcy related funding will ultimately be available to satisfy any potential settlement or judgment arising from Steward era care;

7. The continuing uncertainty surrounding the availability and stability of malpractice protection associated with my prior Steward employment has caused substantial stress, fear, anxiety, and professional instability. The prospect of potentially uninsured personal liability exposure while continuing to practice medicine has created an extraordinarily difficult living and working environment;

8. In addition to the financial burden associated with personally funding my legal defense, the uncertainty regarding continued malpractice protection has negatively affected my personal health, family life, emotional wellbeing, and ability to practice medicine without distraction while continuing to care for patients. I have a trial date approaching in early 2027 and the stress is continuing to increase resulting in many sleepless nights.

Signed under the pains and penalties of perjury this 14 day of May, 2026.

Peter L. Rees

Peter L. Rees, M.D.

Affidavit of Steven G. Yerid, M.D.

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
Debtors.	x	(Jointly Administered)

AFFIDAVIT OF STEVEN G. YERID_____, M.D.

1. I am a physician in good standing and licensed to practice medicine in the Commonwealth of Massachusetts since December of 2005;

2. From April of 2019 until October of 2024, Steward Health Care System, LLC (via its subsidiary Steward Medical Group, Inc.)("Debtor" or "Steward") employed me at Steward Holy Family Hospital ("Hospital"), which was sold after Steward filed these bankruptcy proceedings;

3. Following the Hospital's sale, I remained employed with the new organization through which I have professional liability insurance coverage for events / claims arising out of care provided after the sale date;

4. While I was still practicing at the Hospital and while the Hospital remained owned by Steward, a medical malpractice lawsuit was asserted against me (and others) arising from care rendered during my employment with Steward;

5. At that time, Steward represented that it would provide me with insurance funds both to defend the lawsuit and for indemnity. Counsel was retained on my behalf and performed

substantial work on my behalf in the matter, including retaining a favorable expert witness to support my defense;

6. During the pendency of the litigation, Steward filed for Bankruptcy protection, and after which the Hospital was sold. Initially the entire case was stayed pending the Bankrupty as the hospital Debtor Entity is also a named defendant. However, the Debtor Entity defendant has now been severed out from the remainder of the case and the case is proceeding against me;

7. I have been informed that following Steward's bankruptcy the defense counsel representing me and expert retained to testify on my behalf have not been paid for substantial services they rendered during the pendency of the lawsuit, and I am now personally responsible, both for the defense costs (including experts) as well as any potential judgment a jury may render, despite having been assured I had professional liability coverage;

8. The lawsuit is fast approaching a trial date, current set to begin on **June 9, 2026**. This trial date is expected to go forward absent some intervention from the Bankruptcy Court, notwithstanding Steward's ongoing bankruptcy proceedings and the unresolved issues concerning malpractice insurance funding and defense obligations;

9. As a result, I now face the very frightening reality of proceeding to trial without funded insurance coverage, without funded defense costs, without funded expert support. The purchasing organization of the Hospital will not cover this lawsuit because it arose out of care provided before the Hospital was sold.

10. The lack of funded coverage and defense resources has placed me in an extremely difficult position professionally and financially, including exposing me to personally funded litigation costs, expert fees, adverse judgments, and the very real possibility of filing for bankruptcy;

11. The uncertainty surrounding the availability of malpractice coverage and defense funding has caused substantial hardship and has significantly affected my professional and personal wellbeing.

Signed under the pains and penalties of perjury this 15 day of MAY, 2026.

Steven Geist

Affidavit of Steven G. Yerid, M.D.

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	x	Chapter 11
STEWARD HEALTH CARE SYSTEM, LLC, *et al.*,	x	Case No. 24-90213 (CML)
Debtors.	x	(Jointly Administered)

AFFIDAVIT OF STEVEN G. YERID_____, M.D.

1. I am a physician in good standing and licensed to practice medicine in the Commonwealth of Massachusetts since December of 2005;

2. From April of 2019 until October of 2024, Steward Health Care System, LLC (via its subsidiary Steward Medical Group, Inc.)("Debtor" or "Steward") employed me at Steward Holy Family Hospital ("Hospital"), which was sold after Steward filed these bankruptcy proceedings;

3. Following the Hospital's sale, I remained employed with the new organization through which I have professional liability insurance coverage for events / claims arising out of care provided after the sale date;

4. While I was still practicing at the Hospital and while the Hospital remained owned by Steward, a medical malpractice lawsuit was asserted against me (and others) arising from care rendered during my employment with Steward;

5. At that time, Steward represented that it would provide me with insurance funds both to defend the lawsuit and for indemnity. Counsel was retained on my behalf and performed

substantial work on my behalf in the matter, including retaining a favorable expert witness to support my defense;

6. During the pendency of the litigation, Steward filed for Bankruptcy protection, and after which the Hospital was sold. Initially the entire case was stayed pending the Bankrupty as the hospital Debtor Entity is also a named defendant. However, the Debtor Entity defendant has now been severed out from the remainder of the case and the case is proceeding against me;

7. I have been informed that following Steward's bankruptcy the defense counsel representing me and expert retained to testify on my behalf have not been paid for substantial services they rendered during the pendency of the lawsuit, and I am now personally responsible, both for the defense costs (including experts) as well as any potential judgment a jury may render, despite having been assured I had professional liability coverage;

8. The lawsuit is fast approaching a trial date, current set to begin on **June 9, 2026**. This trial date is expected to go forward absent some intervention from the Bankruptcy Court, notwithstanding Steward's ongoing bankruptcy proceedings and the unresolved issues concerning malpractice insurance funding and defense obligations;

9. As a result, I now face the very frightening reality of proceeding to trial without funded insurance coverage, without funded defense costs, without funded expert support. The purchasing organization of the Hospital will not cover this lawsuit because it arose out of care provided before the Hospital was sold.

10. The lack of funded coverage and defense resources has placed me in an extremely difficult position professionally and financially, including exposing me to personally funded litigation costs, expert fees, adverse judgments, and the very real possibility of filing for bankruptcy;

11. The uncertainty surrounding the availability of malpractice coverage and defense funding has caused substantial hardship and has significantly affected my professional and personal wellbeing.

Signed under the pains and penalties of perjury this 15 day of MAY, 2026.

Steven Geist

EXHIBIT I

Excess Judgments

2026 WL 1248960 (Mich.Cir.Ct.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - MICHIGAN REPORTS
Circuit Court of Michigan, Sixth Judicial Circuit, **Oakland** County.

B.U. v. Oakland Physicians Med. Ctr. LLC

Type of Case:
Medical Malpractice-Facility • Hospital

Intentional Torts • Sexual Assault

Negligence-Other

Synopsis: Psychiatric inpatient was sexually assaulted by mental health technician

General Injury: Post-traumatic stress disorder, mental anguish, depression, fright and shock, and violation of bodily integrity

Jurisdiction:
State: Michigan
County: **Oakland**
Docket/File Number: 2023-198743-NO

Trial Type: Jury
Verdict: Plaintiff, $14,950,000

Range Amount: $5,000,000 - 999,999,999

Date of Incident: July 14, 2022
Date of Filing: February 09, 2023
Verdict/Judgment Date: January 30, 2026

Judge: Kwame L. Rowe
Attorneys:
Plaintiff: Ali H. Koussan, Koussan Law, Detroit, MI
Defendant: Michelle Thurber Czapski, Bodman PLC, Troy, MI; Michelle Kolkmeyer, Bodman PLC, Troy, MI; Rebecca Azar, Bodman PLC, Troy, MI

Experts:
Plaintiff: Gerald Sheiner, M.D., Psychiatrist, Birmingham, MI

Breakdown of Award:
$3,000,000 to plaintiff for past noneconomic damages
$2,000,000 to plaintiff for past economic damages
$8,800,000 to plaintiff for future noneconomic damages
$1,150,000 to plaintiff for future economic damages

Summary of Facts:

Plaintiff **B.U**. reportedly had a history of bipolar disorder and childhood trauma due to extensive physical and sexual abuse. She was admitted to defendant **Oakland Physicians** Medical Center **LLC** d/b/a Pontiac General Hospital on July 1, 2022 for inpatient psychiatric care after a manic episode and a suicide attempt and was placed in a unit with male patients and male staff. On July 14, 2022, the plaintiff was allegedly sexually assaulted by a mental health technician employed by the defendant.

The plaintiff claimed to suffer post-traumatic stress disorder, mental anguish, depression, fright and shock, and violation of her bodily integrity.

The plaintiff asserted that the defendant was negligent and violated the Michigan Mental Health Code by subjecting her to abuse or neglect.

JVR 2605060007

End of Document

2026 WL 801048 (Ala.Cir.Ct.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - ALABAMA REPORTS
Circuit Court of Alabama, Thirteenth Judicial Circuit, Mobile County.

Estate of Haas v. Galla

Type of Case:
Wrongful Death • Adult

Medical Malpractice-Facility • Clinic/Center/Group

Medical Malpractice-Physicians & Health Professionals • Cardiologist

Medical Malpractice-Procedures & Treatment • Catheterization

Medical Malpractice-Procedures & Treatment • Failure to Diagnose/Treat

Synopsis: Cardiologist failed to properly manage patient's unstable angina

General Injury: Death; acute cardiac ischemia, coronary artery heart disease and cardiomegaly

Jurisdiction:
State: Alabama
County: Mobile
Docket/File Number: CV-2021-901463.00

Trial Type: Jury
Verdict: Plaintiff, $50,000,000

Range Amount: $5,000,000 - 999,999,999

Date of Incident: December 31, 2020
Date of Filing: August 18, 2021
Verdict/Judgment Date: March 16, 2026

Judge: Ben H. Brooks
Attorneys:
Plaintiff: George W. Finkbohner III, Cunningham Bounds LLC, Mobile, AL; Lucy E. Tufts, Cunningham Bounds LLC, Mobile, AL; David G. Wirtes Jr., Cunningham Bounds LLC, Mobile, AL; Carmen Chambers, Cunningham Bounds LLC, Mobile, AL
Defendants: Tamela E. Esham, Armbrecht Jackson LLP, Mobile, AL; Scott G. Brown, Armbrecht Jackson LLP, Mobile, AL; Matthew W. Smith, Armbrecht Jackson LLP, Mobile, AL

Experts:
Plaintiff: Carlos Mena-Hurtado, M.D., Interventional Cardiologist, Yale School of Medicine, New Haven, CT; Ahmed Tawakol, M.D., Nuclear Cardiologist, Harvard Medical School, Boston, MA; Robert Quigley, M.D., Protective Medicine & Health Risk Mitigation, Southampton, NY

Breakdown of Award:
$50,000,000 to plaintiff for punitive damages

Summary of Facts:
Daniel **Haas**, 66-years-old, reportedly had a history of coronary artery disease, hypertensive heart disease, mixed hyperlipidemia, and a four-vessel, coronary artery bypass graft (CABG) ten years prior. Christmas Eve, **Haas** reportedly experienced back and shoulder pain and shortness of breath after returning from a hunting trip. Christmas Day, **Haas** reportedly called defendant John **Galla**, M.D., a cardiologist with defendant Cardiology Associates of Mobile Inc. Rather than directing **Haas** to the emergency room or ordering immediate testing, **Galla** reportedly advised rest and an office visit scheduled for three days later, at which time **Haas** would undergo a stress EKG and nuclear stress tests. Results reportedly showed abnormalities. Next, **Haas** reportedly underwent a diagnostic cardiac catheterization performed by **Galla**. The catheterization reportedly revealed significant coronary artery disease and bypass graft deterioration. Following the catheterization, **Galla** reportedly discharged **Haas** home with instructions to follow up after an elective eye surgery.

Haas died in his bed of acute cardiac ischemia due to coronary artery heart disease, the autopsy showing 100 percent occlusion of the left anterior descending artery (LAD) and left circumflex artery, 70 percent stenosis of the right coronary artery and distal stenosis in the LIMA graft, and 100 percent occlusion of the saphenous vein graft to the ramus intermedius, as well as cardiomegaly.

The plaintiff **Estate** of **Haas** brought a wrongful death action based on negligence and wantonness. The plaintiff asserted negligence pertaining to **Galla's** failure to appropriately treat unstable angina, hospitalize for chest pain when first reported, obtain cardiac enzyme lab tests for troponin and creatine kinase, consult with a cardiothoracic surgeon after the catheterization to evaluate whether a repeat CABG was indicated, provide post-catheterization instructions, schedule follow-up appointments, and appropriately assess, treat, hospitalize, and monitor for unstable angina.

The plaintiff sought damages, including punitive damages.

The defendants asserted **Haas** had end-stage heart disease with irreversible damage that could not be corrected through hospitalization, anticoagulation therapy, or surgical intervention.

JVR 2603230016

End of Document

2025 WL 3515201 (N.Y.Sup.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - NEW YORK REPORTS
Supreme Court, Tenth Judicial District, Nassau County, New York.

Gangaram et al. v. Iadevaio et al.

Type of Case:
Medical Malpractice-Physicians & Health Professionals • Anesthesiologist

Medical Malpractice-Procedures & Treatment • Back/Neck

Medical Malpractice-Procedures & Treatment • Informed Consent

Vicarious Liability

Synopsis: Anesthesiologist administered epidural injection resulting in paraplegia

General Injury: Paraplegia, bladder and bowel incontinence

Jurisdiction:
State: New York
County: Nassau
Docket/File Number: 0610647/2021

Trial Type: Jury
Verdict: Plaintiffs, $60,239,512

Range Amount: $5,000,000 - 999,999,999
Date of Incident: November 18, 2019
Verdict/Judgment Date: May 16, 2025

Judge: Leonard D. Steinman
Attorneys:
Plaintiffs: Marijo Adimey, Gair, Gair, Conason, Rubinowitz, Bloom, Hershenhorn, Steigman & Mackauf, New York, NY
Defendants: Bruce M. Brady, Koster, Brady & Nagler, LLP, Rye, NY

Experts:
Plaintiffs: Joshua Kaye, M.D., Pain Management Physician, Kingston, NY

Breakdown of Award:
$11,000,000 to plaintiff David Gangaram for past pain and suffering
$30,000,000 to plaintiff David Gangaram for future pain and suffering
$7,839,601 to plaintiff David Gangaram for future economic damages
$4,127,713 to plaintiff Bibi Gangaram for past loss of spousal services and society
$7,272,198 to plaintiff Bibi Gangaram for future loss of spousal services and society

Summary of Facts:

Plaintiffs David and Bibi **Gangaram** said defendant anesthesiologist Robert J. **Iadevaio**, an agent and/or employee of defendant Long Island Physician Associates PLLC, d/b/a Pain Institute of Long Island, administered a transforaminal epidural steroid injection to David to treat lumbar radiculopathy with right leg pain and numbness.

David reportedly developed paraplegia after receiving the epidural injection into a spinal artery, rather than surrounding tissue, as intended, resulting in a spinal infarct/spinal stroke. Bibi claimed a loss of consortium.

The plaintiffs filed this medical malpractice claim with contentions that **Iadevaio** and his practice vicariously, were negligent in rendering care and treatment to David, including departing from standard medical practices and negligently performing a transforaminal epidural steroid injection. The plaintiffs maintained that the defendant anesthesiologist failed to warn and advise of the risks, hazards, and dangers of the procedure and available alternatives, leading to a lack of informed consent.

JVR 2512040007

End of Document

2022 WL 22854146 (N.Y.Sup.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - NEW YORK REPORTS
Supreme Court, Twelfth Judicial District, Bronx County, New York.

H.Q. Jr. v. Jacobi Med. Ctr. et al.

Type of Case:
Medical Malpractice-Facility • Hospital

Medical Malpractice-Physicians & Health Professionals • Obstetrician/Gynecologist

Medical Malpractice-Procedures & Treatment • Birth Injury

Medical Malpractice-Procedures & Treatment • Vaginal Delivery

Medical Malpractice-Procedures & Treatment • Tracheostomy

Medical Malpractice-Procedures & Treatment • Failure to Diagnose/Treat

Synopsis: Physicians failed to properly manage premature birth

General Injury: Respiratory distress syndrome, chronic lung disease, cerebral palsy and global developmental delays

Jurisdiction:
State: New York
County: Bronx
Docket/File Number: 0350345/2011

Trial Type: Jury
Verdict: Plaintiff, $80,000,000

Range Amount: $5,000,000 - 999,999,999
Verdict/Judgment Date: October 20, 2022

Judge: Joseph E. Capella
Attorneys:
Plaintiff: Michael E. Duffy, Duffy & Duffy PLLC, Uniondale, NY
Defendants (Grimaldi and Inglis): Craig G. Bienstock, Shaub, Ahmuty, Citrin & Spratt LLP, Lake Success, NY

Breakdown of Award:
$10,000,000 to plaintiff for past pain and suffering
$70,000,000 to plaintiff for future pain and suffering

Summary of Facts:
Plaintiff **H.Q. Jr.** reportedly was born premature in 2003, at 23 weeks. The mother reportedly had a documented history of insufficient cervix successfully treated with cerclage. Despite this historical information, physicians at defendant **Jacobi**

Medical Center, owned by defendant The New York City Health and Hospitals Corporation, reportedly decided not to perform prophylactic cerclage, including at 21-weeks, nor did they perform serial transvaginal ultrasound to check on cervical length.

The plaintiff allegedly suffered injuries that included respiratory distress syndrome, chronic lung disease, cerebral palsy and global developmental delays, and reportedly required a tracheostomy and feeding tube.

The plaintiff asserted medical negligence.

At trial, per the verdict form, jurors determined **Jacobi** and its physicians were solely responsible for the plaintiff's injuries. Two other physicians, defendants Meryl Grimaldi, MD and Steven Inglis, MD, who rendered services for another hospital, were found to be not liable.

JVR 2407120025

End of Document

2026 WL 889644 (Md.Cir.Ct.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - MARYLAND REPORTS
Circuit Court of Maryland, Seventh Judicial Circuit, Prince George's County.

White v. UM Capital Reg'l Health Inc. et al.

Type of Case:
Medical Malpractice-Facility • Hospital

Medical Malpractice-Physicians & Health Professionals • Thoracic Surgeon

Medical Malpractice-Physicians & Health Professionals • Nurse

Medical Malpractice-Procedures & Treatment • Failure to Diagnose/Treat

Synopsis: Hospital and staff delayed treatment of popliteal artery injury following knee dislocation

General Injury: Above knee leg amputation

Jurisdiction:
State: Maryland
County: Prince George's
Docket/File Number:

Trial Type: Jury
Verdict: Plaintiff, $18,650,918

Range Amount: $5,000,000 - 999,999,999

Date of Incident: August 05, 2021
Verdict/Judgment Date: March 09, 2026

Judge: Steuart
Attorneys:
Plaintiff: Karen E. Evans, The Cochran Firm, Washington, DC
Defendants (UMCRH, Shock Trauma, UMOA, MEMNP): Mark T. Foley, Sasscer, Clagett & Bucher, Upper Marlboro, MD
Defendants (Biswas, Surgical Assoc.): Michael K. Wiggins, The Wiggins Law Group PC, Columbia, MD
Defendants (Amergis, Simone): Saamia H. Dasti, Waranch & Brown L.L.C., Lutherville, MD

Experts:
Plaintiff: Ralph DeNatale, M.D., Vascular Surgeon, Connecticut Vascular Center L.L.P., North Haven, CT; Joseph Crouse, Ph.D., Forensic Economist, Crouse Economic & Vocational Consulting LLC, Chambersburg, PA
Defendants: Thomas Grogan, M.S., Forensic Economist, Springfield, PA; David Zak, C.R.C., Vocational Rehabilitationist, Pittsburgh, PA
Unspecified: Terrence Sheehan, M.D., Physiatrist, Rockville, MD

Breakdown of Award:

$578,094 to plaintiff for past medical expenses
$3,072,824 to plaintiff for future medical expenses
$15,000,000 to plaintiff for noneconomic damages

Summary of Facts:
Plaintiff Jamie **White** presented to defendant **UM Capital** Regional **Health** Inc. at **UM** Prince George's Hospital Center (UMCRH) after having fallen on ice and dislocating her left knee. According to the plaintiff, testing revealed a popliteal artery injury, but surgical treatment was delayed. Also named as defendants were Shock Trauma Associates, P.A. (Shock Trauma); University of Maryland Orthopaedic Associates, P.A. (UMOA); thoracic surgeon Kunda S. Biswas, M.D. and his employer, Surgical Associates, Chartered; Maryland Emergency Medicine Network Physicians, LLC. (MEMNP); Anna Simone, R.N., and Amergis Healthcare Staffing, Inc. (Amergis).

The plaintiff underwent an above knee amputation of her left leg, allegedly due to a delay in diagnosis and treatment.

According to the plaintiff, all defendants and their staff deviated from the applicable standard of care in the treatment provided. The plaintiff claimed the defendants failed to timely diagnose her popliteal artery injury; failed to appreciate and timely act upon the time-sensitive and emergent nature of her left knee dislocation, limb ischemia, and artery injury; failed to order and ensure timely and simultaneous orthopedic and vascular consultations; failed to ensure timely CTA imaging of the left lower extremity was performed; failed to provide emergent surgical intervention and failed to advocate for and perform hourly neurovascular checks.

The defendants argued that no alleged deviations from the standard of care were causally related to the plaintiff's ultimate outcome and contested the nature, cause, and extent of the plaintiff's damages.

JVR 2603300016

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2025 WL 4653222 (Pa.Com.Pl.) (Verdict and Settlement Summary)

WEST'S JURY VERDICTS - **PENNSYLVANIA** REPORTS
Court of Common Pleas of **Pennsylvania**, First Judicial District, Philadelphia County.

Spencer v. **Tr**. of the **Univ**. of **Pennsylvania et al**.

Type of Case:
Medical Malpractice-Physicians & Health Professionals • Obstetrician/Gynecologist

Medical Malpractice-Procedures & Treatment • Unnecessary Operations

Medical Malpractice-Procedures & Treatment • Hysterectomy

Medical Malpractice-Procedures & Treatment • Informed Consent

Medical Malpractice-Facility • Hospital

Negligent Infliction of Emotional Distress

Negligent Hiring & Supervision • Negligent Supervision

Synopsis: Medical professionals negligently misdiagnosed cancer and performed unnecessary surgery due to contaminated biopsy slides

General Injury: Performance of an unnecessary hysterectomy

Jurisdiction:
State: **Pennsylvania**
County: Philadelphia
Docket/File Number: 2023-01-000053

Trial Type: Jury
Verdict: Plaintiff, $35,000,000

Range Amount: $5,000,000 - 999,999,999

Date of Incident: March 08, 2021
Date of Filing: January 02, 2023
Verdict/Judgment Date: November 20, 2025

Judge: Craig R. Levin
Attorneys:
Plaintiff: Glenn A. Ellis, Freiwald Law PC, Philadelphia, **PA**
Defendants (Tanyi, Penn Medicine): Charles A. Fitzpatrick, Rawle & Henderson LLP, Philadelphia, **PA**; Patrice S. O'Brien, Rawle & Henderson LLP, Philadelphia, **PA**
Defendant (MLHS): Andrew J. Bond, Eckert Seamans Cherin & Mellott LLC, Philadelphia, **PA**

Experts:
Plaintiff: Adam Rosendorff, M.D., Pathologist, Walnut Creek, CA
Unspecified: Jill Tseng, M.D., Gynecologic Oncologist, Orange, CA; John Bouffard, M.D., Pathologist, Summit, NJ; Mitchell Edelson, M.D., Obstetrician/gynecologist, Willow Grove, **PA**

Breakdown of Award:
$35,000,000 to plaintiff for damages
Liability was assigned at 35 percent to defendant Tanyi, paying $12,250,000, and 65 percent to additional defendant MLHS, which paid $22,750,000.

Summary of Facts:
Plaintiff Isis **Spencer** said she was misdiagnosed with aggressive endometrial cancer due to contaminated biopsy slides from Main Line Health/Lankenau Hospital. According to the plaintiff, despite subsequent negative biopsies, defendant obstetrician/gynecologist Dr. Janos Tanyi insisted on surgery, leading to an unnecessary total hysterectomy and bilateral salpingo-oophorectomy. Also named as defendants were the Trustees of The University of **Pennsylvania**, University of **Pennsylvania** Health System d/b/a Penn Medicine, and Hospital of The University of **Pennsylvania** (HUP), with the defendants joining Main Line Health System (MLHS) as an additional defendant.

The plaintiff underwent an unnecessary hysterectomy with an early surgically induced menopause and numerous cognitive and physical complications.

The plaintiff raised claims of medical and corporate negligence, negligent infliction of emotional distress, battery and lack of informed consent against Dr. Tanyi and the Penn defendants. Specifically, the plaintiff claimed these defendants were negligent in failing to have policies and procedures for proper handling of biopsy specimens to avoid unnecessary surgeries; failing to properly train, supervise and monitor clinical and laboratory personnel; failing to detect contamination of biopsy specimens; failing to have systems in place for conflicting diagnostic explanations; failing to compare Main Line and HUP biopsies; failing to offer and/or perform further diagnostic studies; ignoring nonconforming clinical presentation, lack of family history and normal tests, and performing a total hysterectomy and bilateral salpingo-oophorectomy without confirming cancer.

Dr. Tanyi and the Penn defendants claimed it was the negligence of MLHS in negligently performing an endometrial biopsy, contaminating the endometrial biopsy slides, misdiagnosing the plaintiff's condition, failing to determine that the slides had been contaminated and failing to notify the defendants that the Lankenau slides had been contaminated that resulted in the plaintiff's damages. The defendants disputed the plaintiff's lack of informed consent and battery claims.

JVR 2603130019

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EXHIBIT J

Stellar Order & Motion to Enforce

NOTIFY

8/28

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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

SUPERIOR COURT
CIVIL ACTION
NO.: 1784CV00524 13

LINDA BARRETT,
Plaintiff,
V.
MICHAEL STELLER, M.D.,
Defendant.

after a hearing, Allowed. See court's written decision. Hon. T. 11/13/25.

PLAINTIFF'S MOTION TO VACATE DISMISSAL *NISI* AND FOR ENTRY OF JUDGMENT ON SETTLEMENT AGREEMENT

NOW COMES the plaintiff, by and through her counsel, and hereby respectfully requests that this Honorable Court vacate the dismissal *nisi* entered in this case and enter judgment against the defendant for the plaintiff, in the agreed-upon amount of $250,000.00, pursuant to the settlement agreement reached on or about October 18, 2024. Despite having contracted to settle these claims and have them dismissed, the defendant has yet to pay the settlement amount and the plaintiff has not received any such payment. Accordingly, given that a more than reasonable time has elapsed without payment (and with affirmative evidence of intentional breach of such contract), the plaintiff moves for entry of judgment on the settlement contract consistent with the well-established law of the Commonwealth of Massachusetts.

BACKGROUND

This is a medical malpractice claim that the plaintiff brought against the defendant, Michael Stellar, M.D. The case was scheduled for trial on October 21, 2024. A final trial conference was held on October 9, 2024, for which the parties -- the plaintiff and Dr. Stellar, by and through their respective counsel -- appeared at the Suffolk Superior Court.

The parties were negotiating a settlement in the days leading up to the October 18, 2024 final trial conference, with both the plaintiff and the defendant asserting and demonstrating a good

faith interest in settling these claims. Affidavit of Adam R. Satin, Ex. 1, ¶¶ 4–5. On or about October 6, 2024, the plaintiff communicated her reduced demand of $250,000.00 to settle the case to the defendant, by and through the parties' respective counsel. Satin Aff., Ex. 1, ¶ 5. The next day, October 17, 2024, the defendant, again by and through counsel, offered $250,000.00 to settle the claims against the defendant. Satin Aff., Ex. 1, ¶ 6. On October 18, 2024, the plaintiff, again through counsel, informed the defendant that the defendant's offer was accepted and that they had a deal. Satin Aff., Ex. 1, ¶ 6. In so doing, the parties reached an agreement to settle this case, such that the claims against the defendants would be dismissed in exchange and consideration of payment to the plaintiff of $250,000.00. Satin Aff., Ex. 1, ¶ 6._The parties reported to this Honorable Court that day that they had reached a settlement agreement and that there would be no need for trial. Satin Aff., Ex. 1, ¶ 9. The trial was cancelled in reliance on this report by the parties that a settlement agreement had been reached. Satin Aff., Ex. 1, ¶ 9. Dismissal *nisi* was entered while the settlement was pending.

On or about January 8, 2025, the parties jointly moved for an extension of the dismissal *nisi*. Docket No. 36. In support of such joint motion, the parties (including the defendant, by and through his counsel) affirmatively confirmed that a settlement agreement had been reached in this case. Docket No. 36. The parties requested an additional 45 days to finalize the settlement, which this Court granted. Despite the plaintiff's efforts the settlement was not completed during that time (in particular because the plaintiff had not received payment of the settlement funds, Satin Aff., Ex. 1, ¶ 17) and on February 12, 2025, the parties once again moved to extend the *nisi* order. Docket No. 38. In such joint motion, the defendant again confirmed to this Court that the parties had reached a settlement agreement. Docket No. 38. The Court again granted the joint motion. On or about May 1, 2025, the parties jointly requested a third extension of the nisi order. Docket No.

40. Once again, the parties, including the defendants, confirmed to this Court that the parties had reached a settlement agreement. This Court again granted the joint motion.

During the extended *nisi* period, it became clear that the agreed upon payment would not be forthcoming.[1] That apparently remains the case, and the defendant has not paid the $250,000.00 owed under the settlement contract as a condition of the dismissal of the case. Satin Aff., Ex. 1, ¶ 16. The defendant has, however, enjoyed the benefit of the cancellation of the trial and the dismissal of this case, which were entirely predicated on the agreement that the defendant owes $250,000.00 to the plaintiff. The plaintiff has not received any payment whatsoever in fulfillment of the settlement agreement reached on October 18, 2024, Satin Aff., Ex. 1, ¶ 16, leading to the necessity for this motion.

ARGUMENT

I. Entry of Judgment on the Settlement Agreement Between the Plaintiffs and the Defendants Is Authorized by the Law of the Commonwealth on the Undisputed Facts

When a settlement is reached while litigation is pending, the trial court is empowered to enter judgment enforcing such agreement on motion applying principles of contract law. Duff v. McKay, 89 Mass. App. Ct. 538, 542 (2016). Such a motion can be decided on the papers when considered as summary judgment, or after an evidentiary hearing. Id. This practice is well established and regularly followed when settlement agreements are reached but a party fails to meet its obligations under the settlement agreement or attempts to escape such agreement, and

[1] The defendant had requested 60 days to make payment when the agreement was reached, as well as a confidentiality provision. Satin Aff., Ex. 1, ¶¶ 6–7. The plaintiff conditionally accepted this confidentiality provision on the condition that the payment was made within 60 days, and expressly stated that a failure to pay such consideration within 60 days would void any confidentiality regarding the settlement. Satin Aff., Ex. 1, ¶ 7. That 60 came and went without payment being made, voiding any confidentiality and suggesting an unwillingness or inability to pay the agreed upon settlement amount. Satin Aff., Ex. 1, ¶ 16.

numerous appellate decisions (primarily Rule 23.0 summary dispositions) have reiterated and affirmed that a trial court has such authority. See Fecteau Benefits Group v. Knox, 72 Mass. App. Ct. 204, 211–212 (2008); see also Town of Kingston v. High Pines Corp., 105 Mass. App. Ct. 1109 (table), 2025 Mass. App. Unpub. LEXIS 18 (2025); CP 200 State LLC v. CIEE, Inc., 103 Mass. App. Ct. 1128 (table), 2024 Mass. App. Unpub. LEXIS 198 (2024); Wilmington Trust N.A. v. McSharry, 103 Mass. App. Ct. 1123 (table), 2024 Mass. App. Unpub. LEXIS 106 (2024); Cracchiolo v. Bass, 103 Mass. App. Ct. 1110 (table), 2023 Mass. App. Unpub LEXIS 504 (2023); Puopolo v. Denietolis, 103 Mass. App. Ct. 1105 (table), 2023 Mass. App. Unpub. LEXIS 419 (2023); Sotomayor v. Eidolon Optical, LLC, 102 Mass. App. Ct. 1118 (table), 2023 Mass. App. Unpub. LEXIS 217 (2023) (R. 23.0 summary decisions).

Because the law regarding summary judgment on a contract claim controls entry of judgment to enforce a settlement (when done so without an evidentiary hearing), this Court may do so when the record before the court shows "that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Mass. R. Civ. P. 56(c). Though debatably not required by the rules of this Court (as the instant motion, while requesting relief in the nature of summary judgment, is not itself strictly a motion for summary judgment), for the benefit of this Court the plaintiff includes with this motion and incorporates by reference herein a Statement of Facts that the plaintiff asserts are not subject to material dispute akin to the statement required by Superior Court Rule 9A(b)(5)(i).

II. The Undisputable Record Plainly Demonstrates the Existence of a Binding Contract to Settle This Case Between the Plaintiff and the Defendants that Has Been Willfully Breached, Entitling the Plaintiff to Judgment Against the Defendants to Enforce the Settlement

"A settlement agreement is a contract and its enforceability is determined by applying general contract law." Sparrow v. Demonico, 461 Mass. 322, 327 (2012). To form a contract there

must be an agreement amongst the contracting parties as to all material terms; this premise is so well established as to be "axiomatic." Situation Mgmt. Sys. v. Malouf, Inc., 430 Mass. 875, 878 (2000) (citing McCarthy v. Tobin, 429 Mass. 84, 87 (1999), Rosenfield v. United States Trust Co., 290 Mass. 210, 216 (1935)). Not all details regarding any eventual performance need be finalized for a contract to be formed and binding; details such as the expected date of payment or final terms of a document may be subsidiary matters that do not alter the essential element of the agreement, unless specifically negotiated for consideration. See McCarthy, 429 Mass. at 88. If the material terms of an agreement are sufficiently complete and definite, and the parties intend to be bound by those terms at the time of such agreement, a binding contract is formed at that time despite any subsequent inclusion of "ministerial and nonessential terms of the bargain" memorialized in a more "polished memorandum of [the] already binding contract." Id. at 87 (quoting Goren v. Royal Invest., Inc., 25 Mass. App. Ct. 137, 140 (1987).

In this case, it is beyond any meaningful dispute that the parties -- the plaintiff, Linda Barret, and the defendant, Michael Stellar, M.D. -- intended their settlement agreement to form a binding contract to (a) dismiss the claims against the defendant, with prejudice, in exchange for and in consideration of (b) payment in the amount of $250,000.00 to the plaintiff. The terms important to both parties were discussed by and agreed upon by experienced medical malpractice counsel, who have negotiated numerous such settlements in their careers (including such settlements with each other's law firms and with each other specifically). In response to the plaintiff's demand of $250,000.00, Dr. Stellar's counsel, on Dr. Stellar's behalf, offered to settle the claims against Dr. Stellar with a payment to the plaintiff in the amount of $250,000.00 in exchange for a dismissal and release of any and all claims against Dr. Stellar with prejudice and

cancellation of the impending trial against Dr. Stellar. That offer was accepted by the plaintiff the next day, and a contract was formed at that time.[2]

As clear and convincing evidence that a binding agreement to settle this case had been formed, the parties jointly and repeatedly represented to this Court that a settlement agreement between the parties had been reached -- both the day the settlement was first reported, just before the commencement of trial, and in the multiple subsequent requests for extensions of the *nisi* order. These representations were not made by laypersons, inexperienced in the language of the law, negotiating a vague deal that might be misconstrued; the representations were made by experienced, professional litigation counsel who are unquestionably aware that "[a] settlement agreement **is** a contract" that is **enforceable against the parties to it**. Sparrow, 461 Mass. at 327 (emphasis added). On at least three separate occasions, counsel for the defendant (along with counsel for the plaintiff) represented to this Court that **the parties had reached** a "settlement" in this matter: in October of 2024, when first reported, and in January and March of 2025 when the parties jointly requested the *nisi* be extended to finalize the agreed to settlement. There is no

[2] The plaintiff anticipates that the defendant will assert both (a) an expectation that his insurance carrier, Tailored Risk Assurance Co., Ltd. (TRACO), would indemnify him for this loss and pay such monies directly, and (b) that such was allegedly a material term of the contract and/or that the contract was between the plaintiff and TRACO, not plaintiff and the defendant. The law simply does not permit such a construction. The case law is clear that a settlement agreement is enforceable by the parties, against the parties, and TRACO is not (and never has been) a party. See Duff, 89 Mass. App. Ct. at 546–547. Defendant's counsel does not represent TRACO, but rather represents Dr. Steller; there were no claims brought against TRACO, but rather against Dr. Steller; it is not TRACO that was exposed to a likely judgment against him at the time of trial, but rather Dr. Stellar. Moreover, defendant's counsel *did* specifically negotiate material terms at the time the contract was reached -- that the defendant would be permitted 60 days to pay the amount owed, and that, so long as such payment was timely made, a confidentiality provision would be included. The specific negotiation of these terms at the time the contract was reached strongly implies that any terms *not* addressed or negotiated at that time were not material terms of the contract. That TRACO may have breached its contractual obligations to Dr. Stellar to indemnify him for such loss is irrelevant to whether Dr. Stellar is contractually bound to pay the settlement he agreed to, by and through his counsel, in exchange for the cancellation of the trial and dismissal of the case.

reasonable way the defendant can now deny that such contract was formed and is binding on the parties.

Since the settlement agreement was reached, however, the defendant has failed to pay any of the $250,000.00 in settlement monies owed. It is undisputed that, as of the time of this writing, the plaintiff has not received a single dollar of the funds that were promised in exchange for dismissal of the plaintiff's claims. These claims have been dismissed for over eight months, yet the defendant has not paid anything towards satisfaction of his obligations under the contract. This is plainly not just a breach, but a knowing and willful one. An offer to pay $250,000.00 to settle the claims was accepted and, despite the defendant having received the benefit of the bargain (cancellation of the trial, dismissal, and a general release of all claims), the defendant has not paid the monies owed in full or even in part. There is no good faith basis for doing so; the defendant is clearly legally bound by his obligation under the original settlement agreement. Having received the entirety of what he bargained for and, having paid none of what he promised, judgment against the defendant for breach of contract is warranted.

III. The Defendants' Failure to Pay the Agreed Upon Settlement Funds in A Reasonable Time Is a Clear Material Breach of the Settlement Contract

The original settlement agreement included a specific deadline for payment, requested by the defendant: 60 days. Payment within 60 days was also made a condition of the confidentiality agreement reached, and those terms were negotiated at the time the settlement contract was formed. But even assuming, *arguendo*, that there had not been a specifically negotiated time to make payment, that would in no way suggest that the defendant was permitted to indefinitely withhold payment while gaining the benefit of dismissal of the case. "[E]ven in the absence of such a specific requirement, the time for performance [under a contract] does not extend forever but only for a reasonable time." Charles River Park, Inc. v. Boston Redev. Auth., 28 Mass. App. Ct. 795, 814

(1990). When no definite payment or other performance date had been negotiated as part of a contract "courts may infer that the parties intended a 'reasonable' date" of such payment or performance. Duff, 89 Mass. App. Ct. at 545. "What is a reasonable time depends on the nature of the contract, the probable intention of the parties as indicated by it, and the attendant circumstances." Charles River Park, Inc., 28 Mass. App. Ct. at 814. "When, as here, the facts are undisputed, the question of whether an act was done within a reasonable time is a question of law for the court." Dalrymple v. Winthrop, 97 Mass. App. Ct. 547, 555 (2020) (quoting Middleborough v. Middleborough Gas & Elect. Dep't, 47 Mass. App. Ct. 655, 658 (1999) (applying these rules to a settlement agreement that did not include a specific date of completion requirement).

When a party's only obligation under a contract is to make an agreed upon payment, such payment is "an essential and inducing feature of the contract" such that the failure to make such payment is a material breach as a matter of law. Lease-It, Inc. v. Massachusetts Port Auth., 33 Mass. App. Ct. 391, 396 (1992) (holding that where a party's "sole obligation was to pay concession and rental fees" that had undisputedly not been paid, such failure constituted a material breach as a matter of law). Here, there is no dispute that the defendant has not made the requisite payment. There is further no dispute that the defendant has received a signed and executed release, as bargained for, and that this case has been dismissed (and the trial of this matter cancelled) in reliance on the defendant's promise to pay the plaintiff $250,000.00 in settlement of this case. The defendant has failed to make such payment (or make even partial payment) for over eight months, which is a clear, willful, and material breach of the settlement contract. The plaintiff has been more than patient; on this record, this Court can and should find that the failure to make payment for more than nine months is patently unreasonable. This Court can and should enter judgment against

the defendant as a matter of law given that the evidence of this willful breach will be undisputed. Dalrymple, 97 Mass. App. Ct. at 556.

CONCLUSION

Every week in this Commonwealth defendants make reasonable, substantive, offers to settle legitimate claims against them on the eve of trial. When such an offer is accepted, it forms a binding contract to settle the case in exchange for payment of the agreed upon sum, and the attorneys for such parties come before the Court and inform the Court that such settlement agreement has been reached. Trials that are otherwise ready to proceed do not go forward based upon the expectation and obligation that the defendants will comply with their side of these agreements. Defendant Dr. Steller has, on three separate occasions, agreed with the plaintiff and asserted to this Court that the parties reached a settlement agreement, which formed a binding contract as a matter of law. There is no plausible argument, and there is and will be no evidence, to support any claim that the plaintiff has breached the settlement agreement. What is plain from the sworn evidence provided is that the defendant agreed to pay $250,000.00 in exchange for dismissal of the claims him. Those claims have been dismissed, but the plaintiff has not received any amount of the monies owed. This Court is empowered under the law of the Commonwealth to enter judgment against the defendant to enforce such a settlement agreement for just this reason, and the plaintiff respectfully requests that it do so.

WHEREFORE, for the foregoing reasons, the plaintiff, Linda Barrett, respectfully requests this Honorable Court enter judgment for the plaintiff, pursuant to the settlement contract, in the amount of $250,000.00.

Respectfully submitted,

The plaintiff,
By her attorneys,

/s/ Adam R. Satin
ADAM R. SATIN, BBO# 633069
LYNN I. HU, BBO# 690823
PETER A. GHATTAS, BBO# 688872
LUBIN & MEYER, P.C.
28 State Street
Boston, Massachusetts 02109
(617) 720-4447

NOTIFY

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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
CIVIL ACTION
NO. 1784CV00524

LINDA BARRETT,
Plaintiff

Vs.

MICHAEL STELLER, M.D.,
Defendant

DECISION AND ORDER OF PLAINTIFF'S MOTION TO VACATE DISMISSAL *NISI* and FOR ENTRY OF JUDGMENT ON SETTLEMENT AGREEMENT

This case concerns a medical malpractice claim brought by the plaintiff against the defendant, Dr. Michael Steller. The trial was scheduled for October 21, 2024. On or about October 16, 2024, the plaintiff reduced her demand to $250,000.00 to settle. The next day, defendant, through his counsel, offered that amount to settle. On October 18, 2024, both parties reported to this court that they had reached a settlement agreement and thus, the trial was cancelled. Dismissal nisi was entered while the settlement was pending. On January 8, 2025, both parties jointly moved for an extension of the dismissal *nisi*. Both parties reported that a settlement was reached and requested additional time to finalize the settlement. In February 2025, both parties again moved to extend the *nisi* order. In May 2025, both parties sought another extension of the *nisi* order, which was granted. During the extension period, defendant did not pay $250,000.00.

Dr. Steller states that he was employed with St. Elizabeth's Medical Center and Steward Health Care at the time of the alleged medical malpractice. Dr. Steller was provided professional liability insurance through Tailored Risk Assurance Company (TRACO). The Court makes judicial notice of the fact that Steward Health Care System LLC filed for Chapter 11 bankruptcy

in May 2024. TRACO is an insurance company who has not currently filed for bankruptcy and is an insurance company that is still solvent. TRACO indicated to Dr. Steller that there were no funds available to pay the settlement. It has not provided any further explanation as to the nonpayment. Dr. Steller states that he himself did not settle the matter but that TRACO settled the case with the plaintiff. TRACO has now refused to pay $250,000.00 to the Plaintiff. Dr. Steller contends that he never signed any agreement approving the settlement or promising to pay the settlement amount personally. He seeks this court to vacate the settlement agreement and to place this case back on the trial list.

Whether parties have entered into an enforceable settlement agreement may be resolved by a motion to enforce, rather than by asserting a new claim for breach of contract. See *Duff v. McKay*, 89 Mass. app. Ct. 538, 541-543 (2016). A motion to enforce a settlement agreement may be decided without an evidentiary hearing where, as here, no material facts are in dispute; such a motion is "akin to one for summary judgment." *Id.* at 542. "A settlement agreement is a contract, and its enforceability is determined by applying general contract law." *Sparrow v. Demonico*, 461 Mass. 322, 327 (2012). "An enforceable agreement requires (1) terms sufficiently complete and definite, and (2) a present intent of the parties at the time of formation to be bound by those terms." *Targus Group Int'l, Inc. v. Sherman*, 76 Mass. App. Ct. 421, 428 (2010). To form a binding contract, "[t]he parties must give their mutual assent by having a meeting of the minds' on the same proposition of the same terms at the same time." *I&R Mechanical, Inc. v. Hazelton Mfg. Co.*, 62 Mass.App.Ct. 452, 455 (2004), rev denied, 444 Mass. 1102, (2005). "The manifestation of mutual assent between contracting parties generally consist of an offer by one," covering all the material terms of an agreement between the parties, "and the acceptance of [that offer] by the other." *Id.*

First, the Court finds that Dr. Steller gave TRACO and his attorney an actual authority to act on his behalf during the settlement negotiation period. The conversations between the lawyers where they negotiated an amount to settle is clear that they were both bound by their demand and offer numbers between them. Dr. Steller gave actual authority to TRACO and his attorney, and the plaintiff and her attorney relied on it. "Authority is 'the power of the agent to affect the legal relations of the principal by acts done in accordance with the principal's manifestations of consent to him.'" *Haugler v. Zotos*, 446 Mass. 489, 497-98, 845 N.E.2d 322 (2006). Given the representation to the court by both parties that a settlement has been reached, this Court finds that there was an actual authority given to TRACO and to Dr. Steller's attorney, up to the demand amount of $250K.

Second, there was also clear apparent authority to settle the claim. "Apparent authority arises from 'written or spoken words or any other conduct of the principal which, reasonably interpreted, causes a third person to believe that the principal consents to have the act done on his behalf by the person purporting to act for him." *Licata v. GGNSC Malden Dexter, LLC*, 466 Mass. 793, 801, 2 N.E.3d 840 (2014). Apparent authority exists only to the extent that it is reasonable for the plaintiff and her attorney dealing with the Dr. Steller's attorney and TRACO to believe they are authorized. Here, it is reasonable as a general matter, for all parties to negotiate in good faith. See *Artin Serv. Station, Inc. v. Mitri*, 34 Mass. L. Rep. 344 (2017) (where a settlement agreement was enforceable even when the creditor's attorney forged the signature, and where the opposing attorney reasonably could have believed that there was authorization to settle).

As for actual and apparent authority, all parties agree that in medical malpractices cases, the physician's insurance company agrees to pay for the physician's attorney and agrees to pay

any settlement amount. TRACO agreed to settle and agreed to pay $250,000.00. Although Dr. Steller argues that he himself did not agree to the settlement offer and the amount, it is important and crucial to note that Dr. Steller gave the apparent and actual authority to TRACO and his attorney to settle the litigation matter, and that they are therefore bound by settlement agreement on his behalf. See *Merrimack Coll v. KPMG LLP*, 480 Mass. 614, 620 (2018) ("if an agent with actual or apparent authority enters into a contract with a third party, the principal, the principal will be bound by that contract"). No parties presented evidence of TRACO's contract with Dr. Steller. However, it is apparently clear, and Dr. Steller cannot deny that Dr. Steller's right to settle or to litigate was given entirely to TRACO within their contract.

Third, the only material term that mattered—the amount of money to be settled at $250,000.00—was clear and there were no other terms to consider. The only significant, material term to be negotiated and settled was the amount of money. Even though "the presence of undefined or unspecified terms will not necessarily preclude the formation of a binding contract," here, nothing was undefined nor unspecified. *Situation Mgmt. Sys., Inc.v. Malouf, Inc.*, 430 Mass. 875, 878 (2000). There were no essential terms that remained to be negotiated. See *Goren v. Royal Invest., Inc.*, 25 Mass. App. Ct. 137, 141 (1987) (enforceable agreement existed where "all significant economic issues were resolved" and remaining issues were "subsidiary matters").

Fourth, to enforce the terms of the agreement, the parties demonstrated a present intent of the parties at the time of formation to be bound by those terms. The parties must have had the intention to be bound by their agreement at the moment of its formation. See *McCarthy v. Tobin*, 429 Mass. 84 (1999) (intention to be bound is the "controlling fact"). "To ascertain intent, a court considers the words used by the parties, the agreement taken as a whole, and surrounding

facts and circumstances." *Massachusetts Mun. Wholesale Elec. Co. v. Danvers*, 411 Mass. 39, 45-46 (1991). The Court finds TRACO (with full authority given by Dr. Steller) gave assurance to the plaintiff that it would agree to the settlement amount. The Court credits that all parties truly believed that there was a settlement.

Of course, it is entirely unfortunate for Dr. Steller that TRACO, without an explanation, has refused to pay the settlement amount which it has agreed to pay. The Court understands the predicament that Dr. Steller is place in, especially when he has diligently paid his insurance premiums and has expected TRACO to indemnify him for any allegation of negligent medical care. However, Dr. Steller's contract with TRACO is not what is before this Court, and Dr. Steller has his own litigation rights against TRACO.

ORDER

For the foregoing reasons, the plaintiff's motion to vacate dismissal *nisi* and to enforce the settlement agreement is **ALLOWED**.

Dated: 11/13/2025

Ham. J.

Catherine H. Ham
Justice of the Superior Court

EXHIBIT K

Bbuye Motions

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COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, SS.

SUPERIOR COURT
CIVIL ACTION
NO. 1983CV00842

MELISSA CAPPIELLO, PERSONAL REPRESENTATIVE OF THE ESTATE OF ROBERT DAY,
Plaintiff,
V.
STEVEN BBUYE, M.D., and
VERA McCULLEN, P.A.,
Defendants.

PLAINTIFF'S MOTION TO VACATE DISMISSAL AND FOR ENTRY OF JUDGMENT ON SETTLEMENT AGREEMENT

NOW COMES the plaintiff, by and through her counsel, and hereby respectfully requests that this Honorable Court vacate the dismissal *nisi* entered in this case and enter judgment against the defendants for the plaintiff, in the agreed-upon amount of $800,000.00, pursuant to the settlement agreement reached on or about December 1, 2024. Despite having contracted to settle these claims and have them dismissed, the defendant has yet to pay the settlement amount and the plaintiff has not received any such payment. Accordingly, given that a more than reasonable time has elapsed without payment, the plaintiff moves for entry of judgment on the settlement contract consistent with the well-established law of the Commonwealth of Massachusetts.

BACKGROUND

This is a medical malpractice and wrongful death claim that the plaintiff brought against the defendants, Steven Bbuye, M.D., and Vera McCullen, P.A. The case was scheduled for trial on December 2, 2024. The parties were negotiating a settlement in weeks and days leading up to the December 2, 2024 trial, with both the plaintiff and the defendant asserting and demonstrating a good faith interest in settling these claims. Affidavit of Robert M. Higgins, Ex. 1, ¶¶ 4–7. On or

* Upon review, and after a hearing, the motion is allowed. A settlement reported to the court during litigation is enforceable and may be resolved by motion. Duffy v. McKay, 89 Mass. App. Ct. 538, 541–542 (2016). Here, there is no meaningful dispute that the parties to this action contracted to settle the litigation shortly before trial and reported same to the court. See Basis Technology Corp. v. Amazon.com, Inc., 71 Mass. App. Ct. 29, 41–42 (2008) (no error when judge entered judgment to enforce settlement where the agreement "terminated" a trial and the judge relied on parties' email exchanges and an ambiguous report of an accomplished agreement.) The dismissal is hereby vacated and judgment is to be entered in the principal sum of $800,000 in accordance with the parties' intent to be bound by such agreement.

10/31/25

about November 19, 2024, the plaintiff communicated her demand of $2.75M to settle the case to the defendant, by and through the parties' respective counsel. Higgins Aff., Ex. 1, ¶ 5. On or about December 1, 2024, the defendants, again by and their counsel, counter-offered $800,000.00 to settle the claims against the defendants. Higgins Aff., Ex. 1, ¶ 6. That same day the plaintiff, again through counsel, informed the defendants that the defendantss offer was accepted and that they had a deal. Higgins Aff., Ex. 1, ¶ 7. In so doing, the parties reached an agreement to settle this case, such that the claims against the defendants would be dismissed in exchange and consideration of payment to the plaintiff of $800,000.00. Higgins Aff., Ex. 1, ¶ 7. No other terms of the settlement agreement were discussed at that time. Higgins Aff., Ex. 1, ¶ 8. The parties reported the settlement agreement to this Honorable Court on or before December 2, 2024, indicating that there would be no need for trial. Satin Aff., Ex. 1, ¶ 9. The trial was cancelled in reliance on this report by the parties that a settlement agreement had been reached. Higgins Aff., Ex. 1, ¶ 9. Dismissal *nisi* was entered while the settlement was pending.

Despite cooperative efforts by counsel, the parties were unable to complete the settlement agreement before the *nisi* order expired on January 31, 2025, resulting in dismissal of the case. On or about February 4, 2025, the parties jointly moved to vacate the dismissal and for an extension of the *nisi* period. Docket No. 51. In support of such joint motion, the parties (including the defendant, by and through his counsel) affirmatively confirmed that a settlement agreement had been reached in this case. Docket No. 51. The parties requested an additional 60 days to finalize the settlement, which this Court granted. Despite the plaintiff's efforts the settlement was not completed during that time (in particular because the plaintiff had not received payment of the settlement funds, Higgins Aff., Ex. 1, ¶ 16), and the parties jointly sought another extension of the *nisi* period on or about April 10, 2025, Docket No. 52. Once again, the parties represented and

agreed that a settlement agreement had been reached, and the Court once again granted the requested extension. Higgins Aff., Ex. 1, ¶ 12. On or about June 30, 2025, the *nisi* period expired and the case was once again dismissed. Docket No. 53. That same day, the parties once again moved to vacate the dismissal and extend the *nisi* order. Docket No. 54. In such joint motion, the parties, including the defendants, again confirmed to this Court that the parties had reached a settlement agreement. Docket No. 54. The Court again granted the joint motion, indicating that there would be no further extensions beyond September 30, 2025.

During the extended *nisi* period, it became clear that the agreed upon payment would not be forthcoming. That apparently remains the case, and the defendant has not paid the $800,000.00 owed under the settlement contract as a condition of the dismissal of the case. Higgins Aff., Ex. 1, ¶ 16. The defendants have, however, enjoyed the benefit of the cancellation of the trial and the dismissal of this case, which were entirely predicated on the agreement that the defendants owe $800,000.00 to the plaintiff. The plaintiff has not received any payment whatsoever in fulfillment of the settlement agreement reached on December 1, 2024, Higgins Aff., Ex. 1, ¶ 16, leading to the necessity for this motion.

ARGUMENT

I. Entry of Judgment on the Settlement Agreement Between the Plaintiffs and the Defendants Is Authorized by the Law of the Commonwealth on the Undisputed Facts

When a settlement is reached while litigation is pending, the trial court is empowered to enter judgment enforcing such agreement on motion applying principles of contract law. Duff v. McKay, 89 Mass. App. Ct. 538, 542 (2016). Such a motion can be decided on the papers when considered as summary judgment, or after an evidentiary hearing. Id. This practice is well established and regularly followed when settlement agreements are reached but a party fails to meet its obligations under the settlement agreement or attempts to escape such agreement, and

numerous appellate decisions (primarily Rule 23.0 summary dispositions) have reiterated and affirmed that a trial court has such authority. See Fecteau Benefits Group v. Knox, 72 Mass. App. Ct. 204, 211–212 (2008); see also Town of Kingston v. High Pines Corp., 105 Mass. App. Ct. 1109 (table), 2025 Mass. App. Unpub. LEXIS 18 (2025); CP 200 State LLC v. CIEE, Inc., 103 Mass. App. Ct. 1128 (table), 2024 Mass. App. Unpub. LEXIS 198 (2024); Wilmington Trust N.A. v. McSharry, 103 Mass. App. Ct. 1123 (table), 2024 Mass. App. Unpub. LEXIS 106 (2024); Cracchiolo v. Bass, 103 Mass. App. Ct. 1110 (table), 2023 Mass. App. Unpub LEXIS 504 (2023); Puopolo v. Denietolis, 103 Mass. App. Ct. 1105 (table), 2023 Mass. App. Unpub. LEXIS 419 (2023); Sotomayor v. Eidolon Optical, LLC, 102 Mass. App. Ct. 1118 (table), 2023 Mass. App. Unpub. LEXIS 217 (2023) (R. 23.0 summary decisions).

Because the law regarding summary judgment on a contract claim controls entry of judgment to enforce a settlement (when done so without an evidentiary hearing), this Court may do so when the record before the court shows "that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Mass. R. Civ. P. 56(c). Though debatably not required by the rules of this Court (as the instant motion, while requesting relief in the nature of summary judgment, is not itself strictly a motion for summary judgment), for the benefit of this Court the plaintiff includes with this motion and incorporates by reference herein a Statement of Facts that the plaintiff asserts are not subject to material dispute akin to the statement required by Superior Court Rule 9A(b)(5)(i).

II. The Undisputable Record Plainly Demonstrates the Existence of a Binding Contract to Settle This Case Between the Plaintiff and the Defendants that Has Been Willfully Breached, Entitling the Plaintiff to Judgment Against the Defendants to Enforce the Settlement

"A settlement agreement is a contract and its enforceability is determined by applying general contract law." Sparrow v. Demonico, 461 Mass. 322, 327 (2012). To form a contract there

must be an agreement amongst the contracting parties as to all material terms; this premise is so well established as to be "axiomatic." Situation Mgmt. Sys. v. Malouf, Inc., 430 Mass. 875, 878 (2000) (citing McCarthy v. Tobin, 429 Mass. 84, 87 (1999), Rosenfield v. United States Trust Co., 290 Mass. 210, 216 (1935)). Not all details regarding any eventual performance need be finalized for a contract to be formed and binding; details such as the expected date of payment or final terms of a document may be subsidiary matters that do not alter the essential element of the agreement, unless specifically negotiated for consideration. See McCarthy, 429 Mass. at 88. If the material terms of an agreement are sufficiently complete and definite, and the parties intend to be bound by those terms at the time of such agreement, a binding contract is formed at that time despite any subsequent inclusion of "ministerial and nonessential terms of the bargain" memorialized in a more "polished memorandum of [the] already binding contract." Id. at 87 (quoting Goren v. Royal Invest., Inc., 25 Mass. App. Ct. 137, 140 (1987).

In this case, it is beyond any meaningful dispute that the parties—the plaintiff, Melissa Cappiello, Personal Representative of the Estate of Robert Day, and the defendants, Steven Bbuye, M.D. and Vera McCullen, P.A—intended their settlement agreement to form a binding contract to (a) dismiss the claims against the defendants, with prejudice, in exchange for and in consideration of (b) payment in the amount of $800,000.00 to the plaintiff. These terms important to both parties were discussed by and agreed upon by experienced medical malpractice counsel, who have negotiated numerous such settlements in their careers (including such settlements with each other's law firms and with each other specifically). In response to the plaintiff's demand of $2.75M, defendants' counsel, on the defendants' behalf, counter-offered to settle the claims against the defendants for payment to the plaintiff in the amount of $800,000.00 in exchange for a dismissal and release of any and all claims against Dr. Bbuye and P.A. McCullen with prejudice and

cancellation of the impending trial against the defendants. That offer was accepted by the plaintiff the next day, and a contract was formed at that time.

As clear and convincing evidence that a binding agreement to settle this case had been formed, the parties jointly and repeatedly represented to this Court that a settlement agreement between the parties had been reached—both the day the settlement was first reported, just before the commencement of trial, and in the multiple subsequent requests for extensions of the *nisi* order. These representations were not made by laypersons, inexperienced in the language of the law, negotiating a vague deal that might be misconstrued; the representations were made by experienced, professional litigation counsel who are unquestionably aware that "[a] settlement agreement **is** a contract" that is **enforceable against the parties to it**. Sparrow, 461 Mass. at 327 (emphasis added). On at least four separate occasions, counsel for the defendant (along with counsel for the plaintiff) represented to this Court that **the parties had reached** a "settlement" in this matter: in December of 2024, when first reported, and in February, April, and June of 2025 when the parties jointly requested the *nisi* be extended to allow for the finalization of the agreed to settlement. There is no reasonable way the defendants can now deny that such contract was formed and is binding on the parties.

Since the settlement agreement was reached, however, the defendants have failed to pay any of the $800,000.00 in settlement monies owed. It is undisputed that, as of the time of this writing, the plaintiff has not received a single dollar of the funds that were promised in exchange for dismissal of the plaintiff's claims. By the time this motion is filed following service pursuant to Superior Court Rule 9A, these claims will have been dismissed for over eight months, yet the defendants have not paid anything towards satisfaction of their obligations under the contract. This is plainly not just a breach, but a knowing and willful one. An offer to pay $800,000.00 to settle

the claims was accepted and, despite the defendants having received the benefit of the bargain (cancellation of the trial and dismissal of the claims), the defendants have not paid the monies owed in full or even in part. There is no lawful basis for doing so; the defendants are clearly legally bound by their obligation under the original settlement agreement. Having received the entirety of what they bargained for and, having paid none of what they promised, judgment against the defendants for breach of contract is warranted.

III. The Defendants' Failure to Pay the Agreed Upon Settlement Funds in A Reasonable Time Is a Clear Material Breach of the Settlement Contract

The original settlement agreement did not include a specific deadline for payment as a condition of any of its terms. That lack of a specific date of payment, however, in no way suggests that the defendants were permitted to indefinitely withhold payment while gaining the benefit of dismissal of the case. "[E]ven in the absence of such a specific requirement, the time for performance [under a contract] does not extend forever but only for a reasonable time." Charles River Park, Inc. v. Boston Redev. Auth., 28 Mass. App. Ct. 795, 814 (1990). When no definite payment or other performance date had been negotiated as part of a contract "courts may infer that the parties intended a 'reasonable' date" of such payment or performance. Duff, 89 Mass. App. Ct. at 545. "What is a reasonable time depends on the nature of the contract, the probable intention of the parties as indicated by it, and the attendant circumstances." Charles River Park, Inc., 28 Mass. App. Ct. at 814. "When, as here, the facts are undisputed, the question of whether an act was done within a reasonable time is a question of law for the court." Dalrymple v. Winthrop, 97 Mass. App. Ct. 547, 555 (2020) (quoting Middleborough v. Middleborough Gas & Elect. Dep't, 47 Mass. App. Ct. 655, 658 (1999) (applying these rules to a settlement agreement that did not include a specific date of completion requirement).

When a party's only obligation under a contract is to make an agreed upon payment, such payment is "an essential and inducing feature of the contract" such that the failure to make such payment is a material breach as a matter of law. Lease-It, Inc. v. Massachusetts Port Auth., 33 Mass. App. Ct. 391, 396 (1992) (holding that where a party's "sole obligation was to pay concession and rental fees" that had undisputedly not been paid, such failure constituted a material breach as a matter of law). Here, there is no dispute that the defendants have not made the requisite payment, in whole or in part. The defendants have failed to make such payment (or make even partial payment) for over eight months. The plaintiff has been more than patient; on this record, this Court can and should find that the failure to make payment for more than eight months, when the settlement agreement was reached and the plaintiff's claims were dismissed in December of 2024, is patently unreasonable. The defendants' breach of the settlement agreement is plain, plainly willful, and as they have failed to fulfill their only obligation under the contract, plainly material. This Court can and should enter judgment against the defendants as a matter of law given that the evidence of this willful breach will be undisputed. Dalrymple, 97 Mass. App. Ct. at 556.

CONCLUSION

Every week in this Commonwealth defendants make reasonable, substantive, offers to settle legitimate claims against them on the eve of trial. When such an offer is accepted, it forms a binding contract to settle the case in exchange for payment of the agreed upon sum, and the attorneys for such parties come before the Court and inform the Court that such settlement agreement has been reached. Trials that are otherwise ready to proceed do not go forward based upon the expectation and obligation that the defendants will comply with their side of these agreements. Defendants Dr. Bbuye and P.A. McCullen have, on four separate occasions, agreed with the plaintiff and asserted to this Court that the parties reached a settlement agreement, which

as a matter of law forms a binding contract. There is no plausible argument, and there is and will be no evidence, to support any claim that the plaintiff has breached the settlement agreement. What is plain from the sworn evidence provided is that the defendant agreed to pay $800,000.00 in exchange for dismissal of the claims against them. Those claims have been dismissed, but the plaintiff has not received any amount of the monies owed. This Court is empowered under the law of the Commonwealth to enter judgment against the defendants to enforce such a settlement agreement for just this reason, and the plaintiff respectfully requests that it do so.

WHEREFORE, for the foregoing reasons, the plaintiff, Melissa Cappiello, Personal Representative of the Estate of Robert Day, respectfully requests this Honorable Court enter judgment for the plaintiff, pursuant to the settlement contract, in the amount of $800,000.00.

Respectfully submitted,
THE PLAINTIFF,
By her attorneys,

Robert M. Higgins

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COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, ss.

PLYMOUTH SUPERIOR COURT
DOCKET NO. 1983 CV 00842

MELISSA CAPPIELLO, PERSONAL REPRESENTATIVE OF THE ESTATE OF ROBERT DAY,

Plaintiff,

v.

STEVEN BBUYE, M.D. and VERA McCULLEN, P.A.

Defendants.

FILED
COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT DEPT. OF THE TRIAL COURT
PLYMOUTH COUNTY
SEP 25 2025
Clerk of Court

After a hearing, the motion to withdraw is denied, without prejudice, at this time.
10/3/25

MOTION TO WITHDRAW

NOW COMES Allyson Gay, counsel for the Defendants, Steven Bbuye, M.D. and Vera McCullen, P.A., and respectfully requests that this Honorable Court allow her and her firm to withdraw from this case. Grounds in support of this motion are set forth below.

I. BACKGROUND

Counsel for the above Defendants was retained by Steward Health Care System ("Steward") to represent these Defendants. The agreement to represent the Defendants was contingent on Steward timely paying all legal fees and defense costs including fees for deposition transcripts and expert witnesses. The agreement was also predicated on the representation by Steward that the defendants had an insurance policy to cover a settlement or judgment against each of them. At no time has defense counsel agreed that she and her firm would fund litigation, work pro bono, or cover the fees and litigation costs for Steward and/or its malpractice insurer, TRACO International Group S. De R.L. ("TRACO").

Prior to Steward filing for bankruptcy, it owed defense counsel a considerable sum for legal fees, costs and expenses. Steward induced defense counsel to continue carrying significant debt for it, and to continue working on its cases, by representing that the outstanding legal fees, costs and expenses would be paid through the bankruptcy proceedings.

As this Court is aware, Steward and its debtor affiliates, (the "Debtors") filed voluntary petitions for relief under chapter 11 of title 11 of the United States Code (11 U.S.C. § 101, et seq.) (the "Bankruptcy Code") in the United States Bankruptcy Court for the Southern District of Texas (the "Bankruptcy Court"). The Debtors' chapter 11 cases are jointly administered under the lead case captioned Steward Health Care System LLC, et al., Case No. 24-90213 (CML). A complete list of the Debtors in the chapter 11 cases, and copies of the Debtors' chapter 11 petitions are available on the website of the Debtors' claims and noticing agent at: https://restructuring.ra.kroll.com/Steward.

At the time of the bankruptcy filing, Steward owned and operated the largest private physician-owned for-profit healthcare network in the United States. Headquartered in Dallas, Texas, the Debtors' operations included 31 hospitals across eight states, approximately 400 facility locations, 4,500 primary and specialty care physicians, 3,600 staffed beds, and a company-wide workforce of nearly 30,000 employees.

Steward's medical malpractice insurer, TRACO, provides medical malpractice coverage to approximately 1,400 medical practitioners, including approximately 1,200 physicians who were employed by the Debtors and approximately 200 physicians who are in private practice and affiliated with the Debtors.

On December 2, 2024, TRACO filed an Emergency Motion that sought, in part, immediate payment by the Debtors of all premiums due and owing under the Insurance Policies for 2024. A

copy of this motion is attached as **(EXHIBIT A)**. TRACO represented that Steward owed it $35.5 million and stated that Steward failed to pay the 2024 Insurance Premiums of $3.5 million a month and was $35.5 million in arrears. In addition, TRACO stated in its motion that the Debtors continued to hold, and refused to release approximately $72 million in funds belonging to TRACO which are not property of the bankruptcy estate, resulting from the prepetition sale of the assets of Davis Hospital in which TRACO held an equity interest.

On December 6, 2024, TRACO filed a Complaint against Steward in the Bankruptcy Court seeking the same relief in its emergency motion in addition to alleging breach of fiduciary duty and a request for an accounting. A copy of the Complaint is attached as **(EXHIBIT B)**

On May 28, 2025, the chapter 11 Plan of Reorganization ("Plan" or "the Plan") was filed by Steward in the Bankruptcy Court. The 179-page Plan, docket number 4985, includes a list of so called "Preference Defendants" listed on Schedule 1-B. Defense counsel's firm, in addition to other firms that have continued to work on Steward's cases, is listed as a "Preference Defendant." See pertinent pages attached as **(EXHIBIT C).** This means that Steward Bankruptcy attorneys may seek to recoup monies paid to defense counsel's firm, even though Steward still owes defense counsel and his firm a considerable amount.

On May 25, 2025, Kevin M. Epstein, the United States Trustee for the Southern District of Texas (the "U.S.Trustee"), filed an expedited motion for an order dismissing Steward's bankruptcy case or, in the alternative, converting the case to Chapter 7 under 11 U.S.C. § 1112(b). A copy of this motion is attached as **(EXHIBIT D).** In support of the expedited motion, the U.S. Trustee stated that Steward and its debtor affiliates: "are administratively insolvent with no realistic path towards a confirmable plan of reorganization. Ordinary and operational administrative claimants, many of whom provided post-petition life-saving supplies and services to the Debtors, have not

been paid. The administrative burn rate is exorbitant and unsustainable, with expenses continuing to accrue daily. … Although the Debtors have made meaningful progress since the petition date, at this juncture, there is little remaining benefit to stakeholders in the continued administration of these Chapter 11 cases because the Debtors cannot pay the estimated $127 million in administrative claims on the effective date. Proceeding with a contested and expensive confirmation process for a facially unconfirmable plan would only further burden the estate with significant unrecoverable costs. The Debtors' estates simply cannot afford this unnecessary financial gamble." **(EXHIBIT D, p.2).**

The US Trustee also states in his motion that: "The Debtors are seeking to exit these bankruptcy cases with a plan that violates the Bankruptcy Code. A fundamental tenet of bankruptcy law is that administrative creditors are entitled to the highest priority of payment. See 11 U.S.C. § 1129(a)(9). A plan cannot be confirmed unless all administrative expenses are paid in full on the effective date. This is a core promise of the bankruptcy system - administrative claimants who continue to provide goods and services to a debtor after the bankruptcy filing will be paid in full for those goods or services. Here, the Debtors concede in the Disclosure Statement that they cannot pay their administrative claims but suggest an alternative mechanism that does not comply with the Bankruptcy Code. The Administrative Expense Claims Consent Program forces certain administrative claimants (like defense counsel in this case) to accept less than payment in full. Reliance on such mechanism in a chapter 11 case is flawed and impermissible because a chapter 11 plan cannot force administrative claimants to accept lesser terms. A mechanism of forced consent to accept lesser terms is not supported by the Bankruptcy Code or applicable law." According to the Bankruptcy Plan, Steward is seeking to pay 50% of the full amount of the applicable administrative claims.

As reflected on the Bankruptcy Court Docket, numerous objections to confirmation of the Plan by other creditors, based on the same or similar grounds cited by the US Trustee, have been filed. TRACO joined the US Trustee's motion and stated in its joinder motion that, based upon TRACO's calculations, the total amount due and owing from the Debtors is $360 million. **(EXHIBIT E, p.2).**

On July 16, 2024, over numerous objections, the Bankruptcy Court confirmed the Plan filed by Steward.

Prior to the service of this motion, Counsel for the defendant informed Steward and TRACO that he cannot continue representing the Defendant in this case and has asked that this case be reassigned to another defense attorney.

I. ARGUMENT

A. DEFENSE COUNSEL CANNOT EFFECTIVELY REPRESENT THE DEFENDANT AND PROVIDE A ZEALOUS DEFENSE BECAUSE CONTINUED REPRESENTATION OF THE DEFENDANT WOULD CAUSE DEFENSE COUNSEL TO INCUR AN UREASONABLE FINANCIAL BURDEN

In accordance with Massachusetts Rules of Professional Conduct, Rule 1.16 (b)(6) and (7) a lawyer may withdraw from representing a client if: the representation will result in an unreasonable financial burden on the lawyer or has been rendered unreasonably difficult by the client; or other good cause for withdrawal exists.

Steward owes defense counsel a considerable sum for legal fees. In addition, Steward owes expert witness fees and court reporters' fees. After promising to pay defense counsel, Steward did not pay, filed for bankruptcy and now, as set forth above, was trying to pay 50% of what is owed. Additionally, defense counsel's firm is now a "Preference Defendant" in Steward's Plan and may be forced to return money that it was properly paid for defending Steward's healthcare providers in medical malpractice and other actions.

It has been represented that TRACO is now going to pay legal fees and costs for this case, however, TRACO will not pay Steward's debt to defense counsel, and TRACO is dependent solely on Steward for its financing. TRACO's pleadings filed in the Bankruptcy Court state that Steward owes it $360 million **(EXHIBIT E)**. The only reasonably conclusion that can be drawn is that TRACO is not currently and will not be in the future in a financial position to cover the outstanding legal fees and costs resulting in more significant financial losses for defense counsel and his firm. Even if TRACO pays some bills, this will not alleviate Steward's significant debt to defense counsel, and it is unlikely that TRACO will be able to timely pay legal fees, expert witnesses and court reporters for deposition transcripts and other defense costs. This would leave defense counsel as the party responsible for paying these fees, in addition to carrying debt from Steward's unpaid fees and costs.

Defense counsel cannot continue representing the defendant with the hope that TRACO will be able to pay legal fees and costs. TRACO is relying solely on Steward for its funding and, as TRACO's pleadings make clear, it is significantly underfunded. Defense counsel's dedication to the healthcare providers he represents has compelled him to remain as counsel of record for the defendant, however, this is financially unsustainable. Defense counsel cannot afford to continue to incur fees and costs for Steward and TRACO with the hope that, despite what is public record in the Bankruptcy Court, this will somehow work out. Trial fees, costs and expenses will be significant and cannot be covered by defense counsel. Continuing with the defense of this case and others, would threaten the solvency of defense counsel's firm.

B. <u>DEFENSE COUNSEL MUST WITHDRAW FROM REPRESENTING THE DEFENDANTS BECAUSE THE DEFENDANTS' INSURER HAS MISUSED DEFENSE COUNSEL'S SERVICES AND HAS ENGAGED IN CONDUCT THAT DEFNSE COUNSEL FUNDAMENTALLY DIAGRESS WITH</u>

Comment 7 to Massachusetts Rules of Professional Conduct, Rule 1.16 states: "Withdrawal is also permitted if the lawyer's services were misused in the past even if that would materially prejudice the client. The lawyer may also withdraw where the client insists on taking action that the lawyer considers repugnant or with which the lawyer has a fundamental disagreement."

Steward and TRACO utilized defense counsel's services to negotiate a settlement of a medical malpractice case prior to Steward's bankruptcy filing. The settlement was not paid. After Steward filed for bankruptcy, TRACO utilized the services of a partner at defense counsel's firm to negotiate a settlement of a medical malpractice action on the eve of trial. This settlement has also not been paid. Upon information and belief, TRACO has entered into settlement agreements in other cases in Massachusetts, involving other defense firms, that have not been paid.

Counsel for the defendant cannot, ethically and in good conscience, continue to make representations to other attorneys, and negotiate settlements, if TRACO is financially unable or unwilling to pay negotiated settlements when they are due. Counsel for the defendant fundamentally disagrees with his services being used by TRACO to negotiate settlements, and prepare written settlement agreements, knowing that TRACO may not make the settlement payments when due.

Additionally, when it is in a defendant's best interests to settle a medical malpractice case, defense counsel and the defendant must be able to rely on TRACO to settle the case within the limits of a defendant's policy in a timely manner. Defense counsel cannot meaningfully advise the defendant about taking this case to trial, or settling it, because he has no way to determine if the defendant's TRACO insurance policy is still in full force and effect or, if this case is settled, if TRACO will pay the settlement when due.

For the reasons set forth above, counsel for the defendant respectfully requests that she and her firm be allowed to withdraw from this case.

by counsel,

Allyson L. Gay

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agay@ccclaw.org

DATED: 9/10/2025

CERTIFICATE OF SERVICE

I, Allyson L. Gay, attorney for said defendants, hereby make oath that I have this day served a copy of the attached:

MOTION TO WITHDRAW

upon all parties, by email, directed to:

Robert Higgins, Esq.
Lubin & Meyer, PC
28 State Street, 40th Floor
Boston, MA 02109

Steven Bbuye, M.D.
stevenbbuye@gmail.com

V. Jane McCullen, PA
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Steward Health Care System, LLC
c/o Eugene J. Sullivan, Deputy General Counsel

TRACO
c/o David Friend, Vice President

Signed under the pains and penalties of perjury.

Allyson L. Gay

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DATED: 9/10/2025

EXHIBIT A

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	§	**Chapter 11**
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	§	**Case No. 24-90213 (CML)**
	§	**(Jointly Administered)**
Debtors.[1]	§	

EMERGENCY MOTION OF TRACO INTERNATIONAL GROUP S. DE R.L. (I) COMPELLING PAYMENT BY DEBTORS OF PREMIUMS DUE UNDER INSURANCE POLICIES; (II) COMPELLING PAYMENT OF PREPETITION SETTLEMENT AND DEFENSE COSTS IN COMPLIANCE WITH PREVIOUSLY ENTERED ORDERS; (III) COMPELLING ASSUMPTION OR REJECTION OF INSURANCE POLICIES; (IV) LIFTING AUTOMATIC STAY TO PERMIT THE CANCELLATION OF INSURANCE POLICIES; (V) COMPELLING THE RETURN OF TRACO FUNDS HELD BY THE DEBTORS; AND (VI) GRANTING RELATED RELIEF

EMERGENCY RELIEF HAS BEEN REQUESTED. RELIEF IS REQUESTED NOT LATER THAN: 5:00 P.M. ON DECEMBER 17, 2024.

IF YOU OBJECT TO THE RELIEF REQUESTED OR YOU BELIEVE THAT EMERGENCY CONSIDERATION IS NOT WARRANTED, YOU MUST APPEAR AT THE HEARING IF ONE IS SET, OR FILE A WRITTEN RESPONSE PRIOR TO THE DATE THAT RELIEF IS REQUESTED IN THE PROCEEDING PARAGRAPH. OTHERWISE, THE COURT MAY TREAT THE PLEADING AS UNOPPOSED AND GRANT THE RELIEF REQUESTED.

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' proposed claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

MOTION

TRACO International Group S. De R.L. ("TRACO"), counterparty to various insurance policies with Steward Health Care System LLC and its debtor affiliates in these Chapter 11 cases (collectively, the "Debtors"), including, importantly, medical malpractice insurance coverage for the Debtors' hospitals and the doctors and other health care professionals (the "Insurance Policies"), files this Motion pursuant to sections 105, 362, 365 and 503(b)(1)(A) of 11 U.S.C. § 101 et. Seq., Rules 4002, 6006 and 9014 of the Federal Rule of Bankruptcy Procedure, seeking an Order (i) compelling payment by the Debtors of all premiums due and owing under the 2024 Insurance Policies (as defined below) between the Debtors and TRACO; (ii) compelling payment by Debtors of prepetition settlement and defense costs as authorized by prior Order; (iii) compelling the assumption or rejection of the Insurance Policies; (iv) lifting the automatic stay as necessary to permit TRACO to cancel the Debtors' insurance policies; (v) compelling return of TRACO funds held by the Debtors in constructive trust for the benefit of TRACO;[2] and (vi) granting related relief. As grounds for the foregoing relief, TRACO respectfully represents as follows:

Jurisdiction

1. The Court has jurisdiction to consider this matter pursuant to 28 U.S.C. section 1334. This is a core proceeding pursuant to 28 U.S.C. section 157(b). Venue is proper before the Court pursuant to 28 U.S.C. sections 1408 and 1409.

General Background

2. On May 6, 2024, (the "Petition Date"), the Debtors each commenced with this Court a voluntary case under chapter 11 of title 11 of the United States Code (the "Bankruptcy

[2] An adversary proceeding seeking turnover of these funds will be filed shortly.

Code"). The Debtors are authorized to continue to operate their business and manage their properties as debtors in possession pursuant to sections 1107(a) and 1108 of the Bankruptcy Code. No trustee or examiner has been appointed in these chapter 11 cases.

3. On May 16, 2024, the U.S. Trustee appointed the Official Committee of Unsecured Creditors (the "Committee") pursuant to section 1102 of the Bankruptcy Code.

4. As set forth in the First Day Declaration (defined below), as of the Petition Date, the Debtors owned and operated the largest private physician-owned for-profit healthcare network in the United States. Headquartered in Dallas, Texas, the Debtors' operations included 31 hospitals across eight states, approximately 400 facility locations, 4,500 primary and specialty care physicians, 3,600 staffed beds, and a company-wide workforce of nearly 30,000 employees. The Debtors provided care to more than two million patients annually.

5. Additional information, as of the Petition Date, regarding the Debtors' business, capital structure, and the circumstances leading to the commencement of these chapter 11 cases is set forth in the *Declaration of John R. Castellano in Support of Debtors' Chapter 11 Petitions and First-Day Pleadings* [Docket No. 38] (the "First Day Declaration").

Preliminary Statement

By this Motion, TRACO is requesting immediate payment by the Debtors of all premiums due and owing under the Insurance Policies for 2024 in the amount of $35.5 million, in accordance with the prior Orders of this Court authorizing the payment of insurance premiums. TRACO also seeks immediate payment of prepetition settlement and defense costs relating to litigations against the Debtors' hospitals and doctors and health care providers as authorized by prior Order of this Court in the amount of $1.3 million.[3] Failing that, TRACO requests immediate

[3] By Order dated August 23, 2024, this Court authorized the payment of $3.4 million in defense and related costs for prepetition claims, with the option of increasing this amount with the agreement of the

assumption of the Insurance Policies and cure of all outstanding amounts. If the Debtors decline either to pay all outstanding premiums or to assume the Insurance Policies, TRACO seeks relief from the automatic stay, as necessary, to cancel the Debtors' insurance policies relating to the hospitals. Finally, TRACO is also seeking the return to TRACO of funds belonging to TRACO but currently held by the Debtors in constructive trust for TRACO, which are not property of the estate, relating to the prepetition and postpetition sales of certain assets in which TRACO had an equity interest.

TRACO appreciates that, in the time period immediately leading up to the Debtors' bankruptcy filings, all transactions between the Debtors and TRACO were done on an intercompany book basis. However, this was an accommodation to the Debtors at a time when the Debtors were in a transition period. Prior to 2021, the Debtors paid TRACO the monthly premiums due and owing under the relevant insurance policies in cash. In other words, cash payment of premiums was the ordinary course of business for many years and the shift to book entries was made as an accommodation to the Debtors. At the time, TRACO was represented by the same counsel as the Debtors, and the decision to move from a cash system to a system of book entries was made based on the needs of the Debtors' enterprise as a whole and not based on TRACO's individual interests and needs as a stand-alone insurance company. Moreover, this accommodation was made at a time when TRACO had several other hard assets that provided TRACO with security in case the Debtors failed to comply with their obligations. Now, with the Debtors completing the process of liquidating their assets, including the assets in which TRACO holds an interest, TRACO seeks a return to the original status quo and the payment, in cash, of the Debtors' obligations under the Insurance Policies. Such a return to a cash system is necessary

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Committee. Despite repeated requests, only defense costs of $2.1 million have been paid to date.

in order to allow TRACO to fund current obligations, such as payment of prepetition defense costs and settlements, as well as providing appropriate tail coverage for the doctors and other health care providers. Payment in cash of the outstanding premiums for the 2024 Insurance Policies is consistent with prior Court Orders and the Debtors should be compelled to comply.

While, following the Debtors' bankruptcy filing, TRACO was initially willing to allow the Debtors to continue paying certain expenses directly rather than paying premiums to TRACO, the Debtors have failed to provide TRACO with the necessary funding on a timely basis to address TRACO's actual expenses, all of which relate to insurance provided to the Debtors, the Debtors' hospitals or their doctors or other health care professionals. This is not merely a timing issue – given the global settlement and multiple sales of various hospitals, the continued viability of the Debtors is uncertain, at best. Further, following the 2023 sale of various assets held by Davis Hospital & Medical Center LP ("Davis Hospital") and the recent sale of assets owned by Odessa Regional Hospital LP ("Odessa"), TRACO no longer holds significant assets that could be used to fund TRACO's operations if the Debtors fail to timely pay premiums. Although TRACO was entitled to a portion of the proceeds from these transactions (as discussed below), the Debtors continue to improperly withhold these funds, which belong to TRACO and are not property of the estate, and such funds have not been turned over to TRACO.

In order to operate its business with confidence and continue to provide uninterrupted coverage to the insureds, TRACO must be allowed to administer its own finances and return to the original course of business between the parties, which involves the payment of premiums and other monetary obligations directly to TRACO. TRACO will then administer these funds as appropriate. Failure to return to the original course of dealing between the Debtors and TRACO puts the insurance coverage for both the covered doctors and covered hospitals into jeopardy

because without payment the policies could be cancelled. The only way to ensure confidence in those parties, as well as claimants seeking to recover under the Insurance Policies, is for TRACO to be paid the premiums owing under the Insurance Policies and administer them as appropriate.

This is especially important given that the Debtors' available funds are being spent at an alarming rate, and TRACO understands that no less than $113 million has been paid or accrued in professionals' fees alone through October 31, 2024. By contrast, the Debtors have failed to pay the 2024 Insurance Premiums of $3.5 million a month and are now $35.5 million in arrears. As the post-petition premiums under the 2024 Insurance Policies are undoubtedly administrative claims, with equal priority to the professional fees being paid, should there be insufficient cash in the Debtors' estate to pay the premiums and other administrative claims, administrative insolvency may become a significant issue.

Notably, the Debtors continue to enter into stipulations granting claimants relief from the stay to proceed against insurance, while at the same time failing to pay the premiums or provide any other form of funding for TRACO. This leaves TRACO in the position of having to spend money on defense costs or settlements with limited funds. TRACO has pending settlements that need to be funded. Although the Debtors received approval to pay all amounts required under the Insurance Policies, the Committee has taken positions that resulted in the Debtors curtailing their payments to TRACO to be used for settlements and defense costs. It appears that the Committee is acting in a mistaken effort to control the TRACO premiums as though they are the Debtors' property. The premiums are not property of the estate, but rather the property of a non-debtor third party. No party should be supplanting TRACO's management and board decisions with respect to settlement and litigation. This situation is made worse by the fact that the Debtors continue to hold, and refuse to release, approximately $72 million belonging to TRACO which

are not property of the estate, resulting from the prepetition sale of the assets of Davis Hospital in which TRACO held an equity interest. The Debtors have no basis to keep these funds, which are and have always belonged to TRACO.

By this Motion, the Debtors are seeking the immediate payment of 2024 payments due under the Insurance Policies in the amount of $35.5 million and payment of prepetition settlement and defense costs of $1.3 million, as previously authorized by this Court, or, failing that, the immediate assumption or rejection of the Insurance Policies. If the Debtors are unable or unwilling to begin making, at a minimum, payments for outstanding insurance premiums, TRACO will be left with few options other than to cancel the Insurance Policies for the hospitals. Thus, TRACO also seeks relief from the automatic stay as appropriate to cancel these policies.

TRACO is also seeking the immediate return of funds belonging to TRACO in the amount of $72 million in funds held by the Debtors for TRACO's behalf relating to the prepetition sale of Davis Hospital's assets. Because these funds belong to TRACO and are held in trust by the Debtors for TRACO's benefit, there is no basis for the inclusion of them in the Debtors' assets. TRACO is also entitled to a portion of the sale proceeds from the sale of Odessa's assets, as TRACO is a partial owner of this entity. Once an allocation has been made, TRACO is entitled to immediate payment of the funds to which it is entitled as an owner of a portion of Odessa.

For those reasons, as well as others set forth below, TRACO requests immediate payment of all unpaid premiums for 2024 in the amount of $35.5 million and the payment of $1.3 million for prepetition settlement and defense costs. Failing that, TRACO requests immediate assumption of the Insurance Policies and cure of all outstanding amounts or relief from the automatic stay to cancel the Insurance Policies for the Debtors' hospitals. Finally, TRACO requests the immediate return of the $72 million of TRACO's prepetition funds held by the Debtors and the payment of

the portion of the sale proceeds from the postpetition sale of Odessa to which TRACO is entitled.

Factual Background

6. On May 6, 2024, the Debtors filed a motion seeking authorization to continue insurance policies [Docket No. 6] (the "Insurance Motion"). TRACO, a non-debtor affiliate and subsidiary of the Debtors, provides insurance coverage, including malpractice coverage, comprehensive general liability coverage, workers' compensation coverage, employer liability coverage, stop-loss coverage, and certain excess liability coverage to the Debtors and certain of their non-Debtor affiliates (the "Insurance Policies"). See Docket No. 6 ("Insurance Motion") ¶ 26.

7. Specifically, TRACO provides medical malpractice coverage to approximately 1,400 medical practitioners, including approximately 1,200 physicians who are employed by the Debtors and approximately 200 physicians who are in private practice and are affiliated with the Debtors. TRACO does not provide insurance coverage to any entities or individuals, other than the Debtors and the Debtors' hospitals, non-Debtor affiliates, employed physicians, and affiliated physicians and their employers. See Insurance Motion ¶ 27.

8. TRACO contracts directly or indirectly (at TRACO's expense) with service providers, such as third-party administrators, managers, legal advisors, and various consultants (including actuarial consultants, tax advisors, investment managers, compliance officers, and auditors) to manage and administer the various coverages for its members. TRACO, through its third-party administrators, also retains defense counsel to defend against claims covered by its policies, including medical malpractice claims. See Insurance Motion ¶ 27.

9. Immediately prior to the Petition Date, the costs of these services were paid directly by Debtor Steward Health Care System LLC ("SHC") on behalf of TRACO and such

payments resulted in intercompany payables being owed by TRACO to SHC. In addition, any payments covered by the TRACO policies, including defense costs and settlement payments, were paid directly by SHC, and such payments resulted in intercompany payables being owed by TRACO to SHC and set off against the premiums due.

10. Prior to 2021, however, the Debtors paid TRACO the monthly premiums due and owing under the relevant insurance policies in cash. The switch to intercompany transactions was done as an accommodation to the Debtors at a time when they were in a transition period with respect to the hospitals. At the time, TRACO held several assets, including a 12.36% interest in Odessa and a 30.18% equity interest in Davis Hospital, which sold the majority of its assets in 2023. See Voluntary Petition, Case No. 24-90315, page 200 and Voluntary Petition, Case No. 24-90348, page 201. These assets provided TRACO with an alternative source of funding if the Debtors failed to provide funding for their obligations under the applicable insurance policies. These assets have now been sold and TRACO is seeking the payment of funds belonging to TRACO as the result of these transactions, which were held by the Debtors in trust for TRACO's benefit.

11. The aggregate insurance premiums payable to TRACO are approximately $3.5 million per month. See Insurance Motion ¶ 28. Notwithstanding the information set forth in the Insurance Motion, the unpaid annual premiums under the 2024 Insurance Policies are $35.5 million. However, in addition to the premiums, the Insurance Policies provide that the Debtors may be responsible for certain additional payments, and TRACO reserves the right to seek all such amounts.[4]

[4] By this Motion, TRACO is seeking immediate payment of $36.8 million as an administrative expense claim, as that is the amount of the premiums currently due under the Insurance Policies and the $1.3 million previously authorized for payment of prepetition settlement and defense costs, the minimum amount to which TRACO is entitled. TRACO believes, based on an actuarial analysis, that TRACO will

12. At present, for medical malpractice insurance covering affiliated physicians, such physicians pay SHC directly for the cost of the TRACO insurance premiums, and upon the receipt of such payment from physicians, SHC owes a corresponding intercompany payable to TRACO. Each of these intercompany transactions is recorded on the books and records of the Debtors, non-Debtor affiliates, and TRACO, as applicable. See Insurance Motion ¶ 28.

13. Also owing to TRACO is $72 million in funds arising from a 2023 sale transaction involving the assets of Davis Hospital (the "2023 Transaction"). A portion of the proceeds from the sale, in the amount of approximately $72 million, were allocated to TRACO as a return on its equity investment in this asset. TRACO is informed and believe that the Debtors' own internal documents, including but not limited to the Debtors' sources and uses statements, provide that TRACO was entitled to proceeds of no less than $72 million as the result of the 2023 Transaction. Furthermore, TRACO did not allow those proceeds to be pledged in connection with any subsequent transaction. Upon information and belief, the Debtors never reported those funds to the IRS as income and TRACO is not aware if the Debtors attempted to pledge those funds to any other lender. The relevant proceeds of the sale, which belong to TRACO, were initially being held by the Debtors for TRACO's benefit. Now, however, despite repeated requests for the transfer of these funds, which are not property of the Debtors' estate, the Debtors continue to inappropriately withhold the $72 million belonging to TRACO.

14. The Insurance Motion was approved by interim Order [Docket No. 116] (the "Interim Order") on May 7, 2024. The Interim Order approved the payment of premiums to TRACO and authorized the continuance of the Debtors' "Captive Insurer Program in the ordinary

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ultimately need $80-100 million in order to have sufficient funds to cover all obligations under all insurance policies relating to the Debtors, including coverage tails for the physicians and other health care providers. This analysis, however, depends on multiple factors that are difficult to determine at this time.

course and to honor any prepetition and postpetition amounts to TRACO to ensure uninterrupted coverage under their Insurance Policies." Insurance Motion at ¶ 6.

15. This Court subsequently entered a second interim Order [Docket No. 611] (the "Second Order") with respect to the Insurance Motion, authorizing the Debtors to continue their Captive Insurer Program in the ordinary course and pay all obligations under the Insurance Policies, whether incurred before or after the Petition Date, including making payments on behalf of TRACO, while noting that any non-ordinary course payments to be made on behalf of TRACO shall not be made under the authority solely provided by the Second Interim Order. See Docket No. 611 at ¶ 7.

16. Finally, on August 23, 2024, the Court entered a final Order [Docket No. 2166] (the "Final Order" and, collectively with the Interim Order and the Second Order, the "Insurance Orders") again authorizing the Debtors to "pay any prepetition and postpetition amounts owed" add specific to premiums (Final Order at ¶ 1) and continue the Captive Insurer Program "including making payments on behalf of TRACO to honor postpetition obligations under the Captive Insurer Program and any prepetition obligations owed to defense counsel under the Captive Insurer Program up to an aggregate amount of $3.4 million (such amount subject to increase with the consent of the Creditors' Committee or further order of the Court)…" Final Order at ¶ 7. The Final Order further provides that "any cost of defending a Covered Physician against a Covered Claim covered by, and in accordance with the terms of, the Captive Insurer Program ('Defense Costs'), shall be accorded administrative expense priority status in accordance with section 503(b) of the Bankruptcy Code up to the amount of coverage available to the Covered Physician for such Covered Claim and Defense Costs under the Captive Insurer Program." Id. The Debtors should be compelled to comply with such Orders.

17. Following entry of the Insurance Orders, TRACO repeatedly requested payment of the authorized amounts, as well as an increase in the approved funding, and have faced either denials or delays from the Debtors. TRACO previously understood that certain funds, as approved by the Insurance Orders, were being held by the Debtors for payments on behalf of TRACO. Since those payments were not made, TRACO is uncertain what happened to the funds earmarked for payment of obligations under the Insurance Policies and understands that the Debtors' position is that these funds are available to pay postpetition defense costs relating to the individual physicians. TRACO understands that the Debtors are currently depositing $1.25 million a month in an account at Kroll for payment of postpetition medical malpractice claims asserted against physicians. See Supplement to Final Cash Management Order and Rule 2015.3 Disclosure (the "Supplemental Rule 2015.3 Disclosure"), Docket 1956, p. 3.

18. On June 3, 2024, the Court approved an Order regarding postpetition financing, including a budget agreed to by the Debtors and the Committee (as amended from time to time, the "Budget"). See Docket No. 625. Subsequently, on July 10, 2024, the Court approved a second Order regarding postpetition financing. See Docket No. 1538. Pursuant to the Budget agreed to by the Debtors, the secured lenders, and the UCC, the Debtors allocated $3.4 million for payment to TRACO on account of prepetition obligations due pursuant to the Insurance Policies. In addition, despite the Budget providing for the payment of premiums in the ordinary course of the Debtors' business, the monthly premiums have not been paid.

19. On August 13, 2024, the Debtors filed a Supplemental Rule 2015.3 Disclosure which stated, in relevant part: "[t]he Debtors have consulted with their healthcare and regulatory counsel, McDermott Will & Emory LLP, and the Panama captive insurance counsel. The Debtors believe that medical malpractice coverage provided under the Captive Insurance Program has

been and continues to remain in full force and effect and that the Debtors have been and remain in compliance with all legal requirements necessary to maintain the Captive Insurance Program." Supplemental Rule 2015.3 Disclosure, Dkt. 1956, p. 5, paragraph 7.

20. On or around October 11, 2024, this Court approved the sale of Odessa (the "Odessa Sale"). See Docket No. 2887. The Debtors have not provided TRACO with an allocation regarding the proceeds from this sale, if any, that will remain following the payment of applicable debt. Upon this allocation being done, TRACO is requesting direct payment of the funds owing to TRACO as a non-debtor, 12.36% owner of Odessa. See Voluntary Petition, Case No. 24-90348, page 201.

21. As of September 30, 2024, approximately 300 claims have been asserted, formally or informally, with respect to the Insurance Policies. This includes claims asserted not just against the Debtors, which are subject to the automatic stay unless lifted, but also claims asserted directly against the Debtors' medical professionals. Pursuant to the Insurance Policies, TRACO may be obligated to pay certain defense costs and/or indemnity payments up to the amount of the policy limits.

22. As of November 26, 2024, the Debtors have entered into approximately thirty-five stipulations agreeing to lift the automatic stay to permit claimants to proceed against insurance. As the Debtors' insurer, TRACO is then responsible for paying defense costs, settlement amounts, and claims, as set forth in the 2024 Insurance Policies.

23. TRACO has pending settlements that need to be funded.

24. Notwithstanding entry of the Insurance Orders, as well as the inclusion of funds in the Budget to pay TRACO for premiums and other obligations (both prepetition and postpetition) due under the Insurance Policies, as of September 30, 2024, the Debtors have failed

to pay any of the premiums due under the Insurance Policies for 2024.

Relief Requested

A. TRACO requests immediate payment of Premiums due under the Insurance Policies for 2024 and Prepetition Settlement and Defense Costs as Authorized by the Final Order.

25. TRACO respectfully requests that the Court enter an order requiring the Debtors to pay: (1) all premiums owing under the Insurance Policies for 2024 in the amount of $35.5 million; and (2) prepetition settlement and defense costs of $1.3 million as authorized by the Final Order. TRACO requests payment of these amounts within ten (10) days of such order being granted and any future administrative expenses be paid on an ongoing basis.

26. TRACO recognizes that, for the last three years, SHC has not paid premiums to TRACO directly but rather paid obligations on behalf of TRACO, which are then booked as an intercompany transaction. However, given the failure of SHC and the other Debtors to provide the necessary funding to TRACO to satisfy its obligations in the ordinary course of business and the fact that the Debtors will soon not exist, TRACO has no option but to seek direct payment of the premiums owing under the Insurance Policies. The Debtors should not be able to avoid these critical expenses on the simple grounds that they are "intercompany transactions" when their decision not to fund impacts many non-debtor parties, including TRACO, the medical professionals and hospitals covered by the Insurance Policies, and the claimants waiting for payment of claims that have previously been approved by applicable court.

27. Under Section 503 of the Bankruptcy Code, an entity may file a request for payment of an administrative expense. See 11 U.S.C. § 503(a). Administrative expenses that are "actual, necessary costs and expenses of preserving the estate" are entitled to priority. 11 U.S.C.

§ 503(b)(1)(A). A debtor's direct request for goods or services and/or the knowing and voluntary post-petition acceptance of the desired goods or services establishes the element of "actions taken by the trustee or debtor-in-possession." Nabors Offshore Corp. v. Whistler Energy II, L.L.C. (In re Whistler Energy II, L.L.C.), 931 F.3d 432, 443 (5th Cir. 2019). Administrative priority is given to postpetition vendors as an inducement to engage in business transactions with a debtor's estate. See Matter of TransAmerican Nat. Gas Corp., 978 F.2d 1409, 1416, reh'g denied, 983 F.2d 1060 (5th Cir. 1993).

28. A request for priority payment qualifies as an administrative expense claim pursuant to section 503(b)(1)(A) if "(1) the right to payment arose from a postpetition transaction with the debtor estate, rather than from a prepetition transaction with the debtor, and (2) the consideration supporting the right to payment was beneficial to the estate of the debtor." In re Fin. Oversight & Mgmt. Bd. for Puerto Rico, 2021 WL 5024287 (D. PR October 29, 2021); In re Hemingway Transport, Inc., 954 F.2d 1, 5 (1st Cir. 1992).

29. Here, the Debtors have continued to utilize the insurance provided by TRACO after the Petition Date pursuant to the terms of the Insurance Policies by, among other things, stipulating to lift the automatic stay and allowing third parties to proceed against insurance. Thus, the premiums owing under the Insurance Policies are post-petition, and the insurance arose as a result of actions taken by the debtors in possession in these Chapter 11 bankruptcy cases. Further, the Court previously authorized the payment of $1.3 million in prepetition settlement and defense costs, due to the critical nature of TRACO's services to the Debtors.

30. There is no dispute that the premiums for the Insurance Policies qualify as "actual, necessary costs and expenses" of preserving the Debtors' estates since insurance is critical for the Debtors' continued operations. The Debtors recognized the critical nature of these obligations

in the Insurance Motion, stating:

> Continuation and renewal of the Insurance Policies and entry into new Insurance Policies **are essential to preserving the value of the Debtors' businesses, properties, and assets**. In many cases, coverage provided by the Insurance Policies is required by the regulations, laws, and contracts that govern the Debtors' commercial activities, including the Bankruptcy Code and the Operating Guidelines and Reporting Requirements for Debtors in Possession and Trustees (the "Operating Guidelines") published by the Office of the United States Trustee for Region 7 (the "U.S. Trustee"), which require, among other things, that a debtor maintain adequate coverage given the circumstances of its chapter 11 case.

Insurance Motion ¶ 9 (emphasis added).

31. Later the Insurance Motion states:

> The Debtors' use of estate funds to pay obligations arising from the Insurance Policies is justified because such obligations are necessary costs of preserving the Debtors' estates. **The Insurance Policies are essential to the Debtors' operations, as the Debtors would be exposed to significant liability if the Insurance Policies were allowed to lapse or terminate. Such exposure could detrimentally impact the success of these chapter 11 cases.** In addition, failure to timely pay outstanding premiums could expose the Debtors to potential penalties or termination of the policy.
>
> Additionally, maintaining TRACO and the Captive Insurer Program is critical in these chapter 11 cases because **without the coverage TRACO provides, the Debtors and their physicians would be left uninsured against various risks including medical malpractice claims**. Additionally, in certain states, the Debtors' physicians are required by law to carry medical malpractice insurance in order to practice. Thus, if the Captive Insurer Program were to terminate, the Debtors and their physicians would have to seek coverage elsewhere, potentially at much higher costs. Further, should the Debtors' physicians provide care while uninsured, they would be left exposed to potential personal liability from medical malpractice claims, and they would be acting in violation of state laws and regulations. **As such, physicians who rely on coverage from TRACO may refuse to continue to work for the Debtors and could seek employment elsewhere**.

Insurance Motion ¶ 47-48 (emphasis added).

32. For these reasons, among others, it is imperative that TRACO continue to comply with its obligations under the Insurance Policies, which include the payment of prepetition settlement and defense costs for the Debtors' professionals. The Insurance Policies, which include

malpractice coverage for the doctors who practice at many of the Debtors' hospitals, allowed the Debtors to preserve the value of the hospitals pending the sale of these hospitals as a going concern. Without insurance, the Debtors could not have continued to operate, and the sale of the hospitals would have been negatively and materially impacted. Therefore, the Debtors' post-petition use of the insurance provided by TRACO pursuant to the Insurance Policies directly benefited the Debtors' bankruptcy estates and provided material value and benefit to the Debtors' bankruptcy estates after the Petition Date. Accordingly, TRACO is entitled to allowed administrative expense claim.

33. TRACO is entitled to a priority postpetition administrative claim for the unpaid premiums in the amount of $35.5 million as of October 31, 2024 and the unpaid settlement and defense costs in the amount of $1.3 million ("Administrative Expense Claim") pursuant to sections 503(b)(1)(A) and 507(a)(2). TRACO requests that the Court enter an order compelling the Debtors to pay the Administrative Expense Claim within ten (10) days of an order granting this Motion. It is within the Court's discretion to determine the timing of payment of an administrative expense claim under section 503. See In re NE Opco, Inc., 501 B.R. 233, 259 (Bank. D. Del. 2013); In re Garden Ridge Corp., 323 B.R. 136, 143 (Bankr. D. Del. 2005); In re: Amber Stores, Inc., 193 B.R. 819, 825 (Bankr. N.D. Tex. 1996) (stating that the court could order immediate payment where there are sufficient assets in the estate to pay administrative expenses in full).

34. Pursuant to Rule 4002-1(h) of the Bankruptcy Local Rules for the Southern District of Texas, a debtor-in-possession "must **pay on a current basis** all obligations incurred by it in operating its business." B.L.R. 4002-1(h) (emphasis added). Further, debtors "must not incur administrative and priority expenses unless funds are reasonably expected to be generated

to pay them." B.L.R. 4002-1(f). This Court has already exercised its discretion and authorized the payment of the Debtors' obligations under the Insurance Policies.

35. Accordingly, pursuant to Section 503(b)(1)(A) of the Bankruptcy Code, B.L.R. 4002-1, and applicable law, TRACO respectfully requests that the Court enter an order allowing and directing the immediate payment of TRACO's Administrative Expense Claim arising from the Debtors' post-petition use of the services provided by TRACO under the Insurance Policies, in the amount of at least $36.8 million within ten (10) days of entry of an Order approving this Motion.

B. The Debtor should be Compelled to Immediately assume or reject the Insurance Policies.

36. If the Debtors are unwilling to immediately pay TRACO for the 2024 premiums due under the Insurance Policies and keep them current, TRACO respectfully requests that this Court compel the Debtors to either assume or reject the Insurance Policies.

37. Section 365 of the Bankruptcy Code authorizes the Court to require a debtor to assume or reject an executory contract within a specified period of time upon the request of any party to such executory contract:

> In a case under chapter … 11 … of this title, the trustee may assume or reject an executory contract … of the debtor at any time before confirmation of a plan but the court, on the request of any party to such contract or lease, may order the trustee to determine within a specified period of time whether to assume or reject such contract or lease.

11 U.S.C. § 365(d)(2).

38. With respect to a creditor's request that an executory contract or unexpired lease be assumed or rejected, the determination of what constitutes a reasonable time to assume or reject is within the bankruptcy court's discretion and is based on the circumstances of each case.

See In re Dana Corp., 350 B.R. 144, 147-48 (S.D.N.Y. 2006). This provision is intended to "'prevent parties in contractual or lease relationships with the debtor from being left in doubt concerning their status vis-à-vis the estate.'" University Med. Ctr. v. Sullivan (In re University Med. Ctr.), 973 F.2d 1065, 1078-79 (3d Cir. 1992) (quoting S. Rep. No. 989, 95th Cong., 2d Sess. 59 (1978), reprinted in 1978 U.S.C.C.A.N. 5787, 5845). The Court must balance the potential harm to the estate from making an accelerated decision against the possible harm to the counter-party having to wait for assumption or rejection. See, e.g., In re Kmart Corp., 290 B.R. 614, 619 (Bankr. N.D. Ill. 2003).

39. With respect to a creditor's request that an executory contract be assumed or rejected within a shortened period of time, courts consider various factors, including (i) the nature of the interests at stake, (ii) the balance of the harm to the contract parties; (iii) the good to be achieved; (iv) the safeguards afforded to the contract parties; and (v) whether the imposition of a deadline is arbitrary. In re G-1 Holdings, Inc., 308 B.R. 196, 213 (Bankr. D.N.J. 2004); In re Dana Corp., 350 B.R. 144, 147 (Bankr. S.D.N.Y. 2006). Although Section 365 is intended to give debtors reasonable time to assume or reject an executory contract, the Court must balance the harm to the parties, and the time in making a decision should not come at the expense of the nondebtor party to the executory contract. See In re Beker Indus. Corp., 64 B.R. 890, 896-97 (Bankr. S.D.N.Y. 1986).

40. Here, TRACO will suffer significant harm if the Insurance Policies are not assumed or rejected. The Debtors cannot operate under applicable law without appropriate insurance, and failure to pay the outstanding premiums and other amounts owing under the Insurance Policies puts the hospitals, the doctors and other health professionals, and the public at risk. Despite having received authorization to fund their obligations to TRACO in the ordinary

course of business, the Debtors have not paid any premiums due and have paid only a portion of the prepetition defense costs authorized to be paid pursuant to the Insurance Policies. As a result, TRACO may be unable to pay legal fees required to litigate matters, to enter into settlements, or to satisfy other requirements under the terms of the Insurance Policies in a timely manner. Moreover, once TRACO becomes a stand alone entity, these funds are necessary to fund TRACO's regular operations.

41. As set forth above, the Debtors recognized the critical nature of these obligations in the Insurance Motion. See Insurance Motion ¶¶ 9, 47-48. Yet, notwithstanding the express authorization set forth in the Insurance Orders, and approval by the Committee of a budget with funding to cover at least a portion of these expenses, the Debtors have failed to pay TRACO the outstanding premiums or otherwise provide TRACO with sufficient funds to pay defense counsel, work to settle claims within policy limits, or to make indemnity payments. As a result, TRACO may be unable to comply with its obligations under the Insurance Policies in a timely manner. TRACO has a strong interest in having the Debtors perform their obligations and comply with the terms of the Insurance Policies, compliance of which is required by the Bankruptcy Code.

42. The balance of harms also weighs in TRACO's favor. Six months have passed since the Debtors' Chapter 11 filing. During that time, the Debtors have agreed to numerous requests to lift the automatic stay and proceed against insurance – yet failed to fund this insurance. Further, a number of additional litigations which were not stayed by the automatic stay (as they were brought only against non-debtor parties) have been continuing during this period. There are approximately three hundred potential med-mal cases of which approximately 80% involve physicians and other health care providers. As a non-debtor insurance company, TRACO must comply with its legal obligations to the insureds, whether by funding the defense or paying

liabilities pursuant to the terms of the Insurance Policies. In the event that the Debtors do not assume the Insurance Policies and cure all outstanding obligations, TRACO should not be obligated to continue funding defense costs, paying claims, and otherwise complying with the terms of the policies.

43. In reviewing the relevant factors, the balance of factors weighs in favor of requiring an immediate decision by Debtors concerning the assumption or rejection of the Insurance Policies. To the extent that the Debtor elects to assume the Insurance Policies, the Debtor must cure all defaults – including, but not limited to, paying all outstanding premiums.

C. The Automatic Stay Should be Lifted to Permit TRACO to Cancel the Insurance Policies for the Debtors' Hospitals for Non-Payment of Premiums.

44. Unless the Debtors' failure to pay premiums is remedied immediately, TRACO has no choice but to cancel the Insurance Policies relating to the Debtors and their hospitals.[5] Therefore, unless the Debtors pay the $36.8 million requested by this Motion immediately, TRACO requests, pursuant to sections 105(a) and 362(d)(1) of the Bankruptcy Code, that the Court to enter an order lifting the automatic stay provisions of section 362(a) of the Bankruptcy Code to permit TRACO to exercise any and all rights and remedies it has under the 2024 Insurance Policies and applicable law, including without limitation, cancelling the policies.

45. Pursuant to 11 U.S.C. § 362(d)(1), upon request of a party in interest, the court shall grant relief from the automatic stay for cause. "Cause" is not defined under section 362(d)(1) and the lack of definition has been interpreted to permit courts to determine cause on a case-by-case basis. Reitnauer v. Tex. Exotic Feline Found. (In re Reitnauer), 152 F.3d 341, 343, n. 4 (5th Cir. 1998); Bonneville Power Admin. v. Mirant Corp. (In re Mirant Corp.), 440 F.3d 238, 253

[5] For the avoidance of doubt, TRACO does not intend to cancel the insurance policies related to the individual physicians.

(5th Cir. 2006) (explaining that the "lack of definition" of cause affords "flexibility to the bankruptcy courts"). Here, cause exists to lift the automatic stay because the Debtors are not in compliance with the terms of the 2024 Insurance Policies. The Debtors' right to insurance coverage provided by TRACO derives from and is conditioned upon payment of monthly premiums. Here, the Debtors have failed to make a single monthly premium payment despite repeated requests and obtaining authority to do so from this Court.

46. The Debtors' failure to timely pay premiums under the 2024 Insurance Policies, despite receiving Court authority to do so and there being no dispute over the amount of the premiums due and owing, shows that TRACO is not adequately protected and that additional cause exists for granting relief from the automatic stay pursuant to section 362(d)(1) to permit TRACO to cancel the 2024 Insurance Policies as to the Debtors and their hospitals.

D. The Debtor should be Compelled to Immediately Pay TRACO Funds Relating to the 2023 Transaction and the Odessa Sale.

47. The Debtors have now sold the majority of their assets. Given the global settlement and multiple sales of various hospitals, the continued viability of the Debtors is uncertain. In order to operate its business with confidence and continue to provide uninterrupted coverage to the insureds, TRACO must be allowed to administer its own finances and return to the ordinary course of business prior to 2021. Accordingly, the Debtors should immediately turn over $72 million, which are TRACO's funds realized from the 2023 Transaction and are not property of the Debtors' estate and are currently held by the Debtors in constructive trust for TRACO.

48. Whether an asset is property of a bankruptcy estate is governing by 11 U.S.C. §

541. Section 541(d) states that:

> Property in which the debtor holds, as of the commencement of the case, only legal title and not an equitable interest, such as a mortgage secured by real property, or an interest in such a mortgage, sold by the debtor but as to which the debtor retains legal title to service or supervise the servicing of such mortgage or interest, becomes property of the estate under subsection (a)(1) or (2) of this section only to the extent of the debtor's legal title to such property, but not to the extent of any equitable interest in such property that the debtor does not hold.

11 U.S.C. § 541(d).

49. The Debtors held the sale proceeds from the 2023 Transaction for the benefit of TRACO, thereby establishing a fiduciary relationship under Delaware law. As fiduciaries, the Debtors had a duty to act in the best interest of TRACO concerning these funds. The Debtors' failure to remit the proceeds to TRACO constitutes a breach of this fiduciary duty. TRACO is entitled to turnover of the proceeds from the 2023 Transaction, which are held by the Debtors in constructive trust and are not property of the Debtors' estates. Under Delaware law,"[a]lthough a constructive trust typically is imposed when the defendant wrongfully obtains specific property or identifiable proceeds of specific property from the plaintiff, this equitable remedy also can be applied to the recovery of money when the right asserted by the plaintiff is distinctly equitable in nature, including a right arising from breach of a fiduciary duty. *Standard Chlorine of Delaware, Inc. v. Sinibaldi*, 821 F.Supp. 232, 254 (D. Del. 1992). *See also Sanders v. Wang*, No. 16640, 1999 WL 1044880, at *10 (Del. Ch. Nov. 8, 1999) ("It is, of course, fundamental that a fiduciary who breaches his duty is liable for any loss suffered by the beneficiary of his trust and any profit made through the breach of trust may be disgorged through the device of constructive trust.").

50. Similarly, following an appropriate accounting, the Debtors must turn over the proceeds to which TRACO is entitled from the sale of Odessa's assets.

51. Pursuant to its equitable powers under section 105(a) of the Bankruptcy Code, the

Court has authority to require performance because compliance with state insurance laws is "necessary or appropriate to carry out the provisions" of the Bankruptcy Code, the ability to reorganize. 11 U.S.C. § 105(a); see also Marrama v. Citizens Bank, 548 U.S. 365, 375 (2007) (Section 105(a) grants bankruptcy judges "broad authority . . . to take any action that is necessary or appropriate to prevent an abuse of process") (citations and internal quotations omitted); In re Southmark Corp., 49 F.3d 1111, 1116 (5th Cir. 1995) (citations and internal quotations omitted).

52. As stated above, TRACO agreed to record transactions between the Debtors and TRACO on an intercompany book basis as an accommodation to the Debtors at a time when they were in a transition period. Now, however, given the Chapter 11 filing and the various asset sales, it is imperative that TRACO have the ability to access all of its assets – specifically including TRACO's funds currently held by the Debtors.

53. In order to operate its business with confidence and continue to provide uninterrupted coverage to the insureds, TRACO must be allowed to administer its own finances. TRACO should be given all of the funds to which it is entitled pursuant to the Debtors' books and records – including but not limited to TRACO's share of the funds from the 2023 Transaction and the Odessa Sale. These funds belong to TRACO and there is no basis for the inclusion of them in the Debtors' assets.

54. For those reasons, TRACO requests immediate payment of the $72 million of TRACO's prepetition funds held by the Debtors and the portion of the sale proceeds from Odessa to which TRACO is entitled following an appropriate allocation.

Waiver of Stay of Effectiveness of Order

55. TRACO seeks a waiver of the 14-day stay of the effectiveness of the order terminating the automatic stay, if applicable, pursuant to Bankruptcy Rule 4001(a)(3) so that

TRACO may take immediate action to terminate the Insurance Policies as to the Debtors and the Debtors' hospitals.

Request for Emergency Consideration

56. Pursuant to Local Bankruptcy Rule 9013-1(i), TRACO respectfully requests that the Motion be considered on an emergency basis. The Debtors have failed to pay premiums under the 2024 Insurance Policies, notwithstanding receiving authority to do so from this Court. The Debtors continue to enter into stipulations to lift the automatic stay to allow Claimants to proceed to judgment and collect against insurance, while failing to provide TRACO without paying current obligations under the Insurance Policies. Absent emergency consideration, this Motion will not be heard until early January 2025, during which time TRACO will be forced to continue to pay claimants in the ordinary course of business, while the Debtors fail to pay outstanding premiums. The parties have been negotiating a potential global settlement, but those negotiations have stalled. As a result, funding of TRACO is uncertain and whether the Debtors will be compelled to fund TRACO is important in the context of maintaining the Insurance Policies and negotiating and settling medical malpractice claims. Accordingly, TRACO respectfully requests that the Court consider this Motion on an expedited basis.

Conclusion

WHEREFORE, for the foregoing reasons and premises considered, TRACO respectfully requests that this Court order that:

1. TRACO's Administrative Expense Claim pursuant to section 503(b)(1)(A) is allowed and authorized in the amount of $36.8 million, and the Debtors are directed to make payment to TRACO of all outstanding amounts within ten (10) days of entry of the Court's order;

2. The Debtors must assume or reject the Insurance Policies within ten (10) days of

the entry of the Court's order;

3. Lifting the automatic stay, as appropriate, if the Debtors fail to pay the outstanding premiums within ten (10) days of entry of the Court's order to permit TRACO to cancel the 2024 Insurance Policies as to the Debtors and their hospitals;

4. Compelling return of TRACO funds held by the Debtors to TRACO; and

5. For such other and further relief to which TRACO may be justly entitled.

Respectfully submitted,

Dated: December 2, 2024

By: /s/ Timothy Walsh

Timothy Walsh (admitted pro hac vice)
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Counsel for TRACO International Group S. De R.L.

CERTIFICATE OF SERVICE

I hereby certify that on December 2, 2024 all counsel of record who are deemed to have consented to electronic service are being served with a copy of this document via the Court's CM/ECF system.

/s/ Timothy Walsh
Timothy Walsh

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	§	
	§	
	§	**Chapter 11**
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	§	
	§	**Case No. 24-90213 (CML)**
	§	
Debtors.[1]	§	**(Jointly Administered)**
	§	
	§	

DECLARATION OF RUBEN JOSE KING-SHAW JR IN SUPPORT OF EMERGENCY MOTION OF TRACO INTERNATIONAL GROUP S. DE R.L. (I) COMPELLING PAYMENT BY DEBTORS OF PREMIUMS DUE UNDER INSURANCE POLICIES; (II) COMPELLING PAYMENT OF PREPETITION SETTLEMENT AND DEFENSE COSTS IN COMPLIANCE WITH PREVIOUSLY ENTERED ORDERS; (III) COMPELLING ASSUMPTION OR REJECTION OF INSURANCE POLICIES; (IV) LIFTING AUTOMATIC STAY TO PERMIT THE CANCELLATION OF INSURANCE POLICIES; (V) COMPELLING THE RETURN OF TRACO FUNDS HELD BY DEBTORS; AND (VI) GRANTING RELATED RELIEF

I, Ruben Jose King-Shaw Jr, submit this Declaration pursuant to 28 U.S.C. section 1746, and declare as follows to the best of my knowledge, information, and belief:

1. I am the Chairman and President of TRACO International Group S. De R.L. ("TRACO"), which is a counterparty to various insurance policies with Steward Health Care System LLC and its debtor affiliates in these Chapter 11 cases (collectively, the "Debtors") including medical malpractice insurance coverage for the Debtors' hospitals and the doctors and other health care providers.

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

2. I am authorized to submit this Declaration on behalf of TRACO and in support of its *Motion of R C International roup S. D . R. . i Co pelling Pay ent by Debtors of Pre iu s Due under Insurance Policies ii Co pelling Pay ent of Prepetition Settle ent and Defense Costs in Co pliance with Previously ntered rders iii Co pelling ssu ption or Re ection of Insurance Policies iv ifting uto atic Stay to Per it the Cancellation of Insurance Policies v Co pelling Return of R C Funds eld by Debtors and vi ranting Related Relief* (the "Motion").

3. All facts set forth in this Declaration are based upon my personal knowledge or information provided to me by TRACO employees and advisors, and review of relevant documents maintained by TRACO in the ordinary course of business. If called to testify as a witness in this matter, I would testify competently to the facts set forth in this Declaration.

4. On May 6, 2024, I am informed that the Debtors filed a motion seeking authorization to continue insurance policies (the "Insurance Motion"). TRACO, a non-debtor affiliate and subsidiary of the Debtors, provides insurance coverage, including malpractice coverage, comprehensive general liability coverage, workers' compensation coverage, employer liability coverage, stop-loss coverage, and certain excess liability coverage to the Debtors and certain of their non-Debtor affiliates (the "Insurance Policies").

5. TRACO provides medical malpractice coverage to approximately 1,400 medical practitioners, including approximately 1,200 physicians who are employed by the Debtors and approximately 200 physicians who are in private practice and are affiliated with the Debtors. TRACO does not provide insurance coverage to any entities or individuals, other than the Debtors and the Debtors' hospitals, non-Debtor affiliates, employed physicians, and affiliated physicians and their employers.

6. TRACO contracts directly or indirectly (at TRACO's expense) with service providers, such as third-party administrators, managers, legal advisors, and various consultants (including actuarial consultants, tax advisors, investment managers, compliance officers, and auditors) to manage and administer the various coverages for its members. TRACO, through its third-party administrators, also retains defense counsel to defend against claims covered by its policies, including medical malpractice claims.

7. Immediately prior to the Petition Date, the costs of these services were paid directly by Debtor Steward Health Care System LLC ("SHC") on behalf of TRACO and such payments resulted in intercompany payables being owed by TRACO to SHC. In addition, any payments covered by the TRACO policies, including defense costs and settlement payments, were paid directly by SHC, and such payments resulted in intercompany payables being owed by TRACO to SHC and set off against the premiums due.

8. Prior to 2021, however, the Debtors paid TRACO the monthly premiums due and owing under the relevant insurance policies in cash. The switch to intercompany transactions was done as an accommodation to the Debtors at a time when they were in a transition period with respect to the hospitals. At the time, TRACO held several assets, including a 12.36% interest in Odessa Regional Hospital LP ("Odessa") and a 30.18% equity interest in Davis Hospital & Medical Center LP ("Davis Hospital"), which sold the majority of its assets in 2023. See Voluntary Petition, Case No. 24-90315, page 200 and See Voluntary Petition, Case No. 24-90348, page 201. These assets provided TRACO with an alternative source of funding if the Debtors failed to provide funding for their obligations under the applicable insurance policies. These assets have now been sold and TRACO is seeking the payment of funds belonging to TRACO as the result of these transactions, which were held by the Debtors in trust for TRACO's benefit.

9. The aggregate insurance premiums payable to TRACO are approximately $3.5 million per month. Notwithstanding the information set forth in the Insurance Motion, the unpaid annual premiums under the 2024 Insurance Policies are $35.5 million. However, in addition to the premiums, the Insurance Policies provide that the Debtors may be responsible for certain additional payments, and TRACO reserves the right to seek all such amounts.

10. At present, for medical malpractice insurance covering affiliated physicians, such physicians pay SHC directly for the cost of the TRACO insurance premiums, and upon the receipt of such payment from physicians, SHC owes a corresponding intercompany payable to TRACO. Each of these intercompany transactions is recorded on the books and records of the Debtors, non-Debtor affiliates, and TRACO, as applicable.

11. Also owing to TRACO is $72 million in funds arising from a 2023 sale transaction involving the assets of Davis Hospital (the "2023 Transaction"). A portion of the proceeds from the sale, in the amount of approximately $72 million, were allocated to TRACO as a return on its equity investment in this asset. TRACO is informed and believe that the Debtors' own internal documents, including but not limited to the Debtors' sources and uses statements, provide that TRACO was entitled to proceeds of no less than $72 million as the result of the 2023 Transaction. Furthermore, TRACO did not allow those proceeds to be pledged in connection with any subsequent transaction. Upon information and belief, the Debtors never reported those funds to the IRS as income and TRACO is not aware if the Debtors attempted to pledge those funds to any other lender. The relevant proceeds of the sale, which belong to TRACO, were initially being held by the Debtors for TRACO's benefit. Now, however, despite repeated requests for the transfer of these funds, which are not property of the Debtors' estate, the Debtors continue to inappropriately withhold the $72 million belonging to TRACO.

12. I am informed that the Insurance Motion was approved by interim Order [Docket No. 116] (the "Interim Order") on May 7, 2024. The Interim Order approved the payment of premiums to TRACO and authorized the continuance of the Debtors' "Captive Insurer Program in the ordinary course and to honor any prepetition and postpetition amounts to TRACO to ensure uninterrupted coverage under their Insurance Policies." Insurance Motion at ¶ 6.

13. I am informed that this Court subsequently entered a second interim Order [Docket No. 611] (the "Second Order") with respect to the Insurance Motion, authorizing the Debtors to continue their Captive Insurer Program in the ordinary course and pay all obligations under the Insurance Policies, whether incurred before or after the Petition Date, including making payments on behalf of TRACO, while noting that any non-ordinary course payments to be made on behalf of TRACO shall not be made under the authority solely provided by the Second Interim Order. See Docket No. 611 at ¶ 7.

14. I am informed that, on August 23, 2024, the Court entered a final Order [Docket No. 2166] (the "Final Order" and, collectively with the Interim Order and the Second Order, the "Insurance Orders") again authorizing the Debtors to "pay any prepetition and postpetition amounts owed" (Final Order at ¶ 1) and continue the Captive Insurer Program "including making payments on behalf of TRACO to honor postpetition obligations under the Captive Insurer Program and any prepetition obligations owed to defense counsel under the Captive Insurer Program up to an aggregate amount of $3.4 million (such amount subject to increase with the consent of the Creditors' Committee or further order of the Court)…" Final Order at ¶ 7. The Final Order further provides that "any cost of defending a Covered Physician against a Covered Claim covered by, and in accordance with the terms of, the Captive Insurer Program ('Defense Costs'), shall be accorded administrative expense priority status in accordance with section 503(b) of the

Bankruptcy Code up to the amount of coverage available to the Covered Physician for such Covered Claim and Defense Costs under the Captive Insurer Program." Id. I believe that the Debtors should be compelled to comply with such Orders.

15. Following entry of the Insurance Orders, TRACO repeatedly requested payment of the authorized amounts, as well as an increase in the approved funding, and have faced either denials or delays from the Debtors. TRACO previously understood that certain funds, as approved by the Insurance Orders, were being held by the Debtors for payments on behalf of TRACO. Since those payments were not made, TRACO is uncertain what happened to the funds earmarked for payment of obligations under the Insurance Policies and understands that the Debtors' position is that these funds are available to pay postpetition defense costs relating to the individual physicians. TRACO understands that the Debtors are currently depositing $1.25 million a month in an account at Kroll for payment of postpetition medical malpractice claims asserted against physicians. See Supplement to Final Cash Management Order and Rule 2015.3 Disclosure (the "Supplemental Rule 2015.3 Disclosure"), Docket 1956, p. 3.

16. I am informed that, on June 3, 2024, the Court approved an Order regarding postpetition financing, including a budget agreed to by the Debtors and the Committee (as amended from time to time, the "Budget"). See Docket No. 625. Subsequently, on July 10, 2024, the Court approved a second Order regarding postpetition financing. See Docket No. 1538. Pursuant to the Budget agreed to by the Debtors, the secured lenders, and the UCC, the Debtors allocated $3.4 million for payment to TRACO on account of prepetition obligations due pursuant to the Insurance Policies. In addition, despite the Budget providing for the payment of premiums in the ordinary course of the Debtors' business, the monthly premiums have not been paid.

17. I am informed that, on August 13, 2024, the Debtors filed a Supplemental Rule 2015.3 Disclosure which stated, in relevant part: "[t]he Debtors have consulted with their healthcare and regulatory counsel, McDermott Will & Emory LLP, and the Panama captive insurance counsel. The Debtors believe that medical malpractice coverage provided under the Captive Insurance Program has been and continues to remain in full force and effect and that the Debtors have been and remain in compliance with all legal requirements necessary to maintain the Captive Insurance Program." Supplemental Rule 2015.3 Disclosure, Dkt. 1956, p. 5, paragraph 7.

18. I am informed that, on or around October 11, 2024, this Court approved the sale of Odessa (the "Odessa Sale"). See Docket No. 2887. The Debtors have not provided TRACO with an allocation regarding the proceeds from this sale, if any, that will remain following the payment of applicable debt. Upon this allocation being done, TRACO is requesting direct payment of the funds owing to TRACO as a non-debtor, 12.36% owner of Odessa. See Voluntary Petition, Case No. 24-90348, page 201.

19. I am informed that, as of September 30, 2024, approximately 300 claims have been asserted, formally or informally, with respect to the Insurance Policies. This includes claims asserted not just against the Debtors, which are subject to the automatic stay unless lifted, but also claims asserted directly against the Debtors' medical professionals. Pursuant to the Insurance Policies, TRACO may be obligated to pay certain defense costs and/or indemnity payments up to the amount of the deductible.

20. There are approximately three hundred potential med-mal cases of which approximately 80% involve physicians and other health care providers.

21. TRACO has pending settlements that need to be funded.

22. I am informed that, as of November 26, 2024, the Debtors have entered into approximately thirty-five stipulations agreeing to lift the automatic stay to permit claimants to proceed against insurance. As the Debtors' insurer, TRACO is then responsible for paying defense costs, settlement amounts, and claims, as set forth in the 2024 Insurance Policies.

23. Notwithstanding entry of the Insurance Orders, as well as the inclusion of funds in the Budget to pay TRACO for premiums and other obligations (both prepetition and postpetition) due under the Insurance Policies, as of September 30, 2024, the Debtors have failed to pay any of the premiums due under the Insurance Policies for 2024.

24. I declare under penalty of perjury that the foregoing statements made by me are true and correct to the best of my knowledge, information, and belief.

Dated: December 2, 2024

/s/ Ruben Jose King-Shaw Jr.
Ruben Jose King-Shaw Jr
Chairman and President
TRACO International Group S. De R.L.

PROPOSED ORDER

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	§	
	§	
	§	**Chapter 11**
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	§	
	§	**Case No. 24-90213 (CML)**
	§	
Debtors.[1]	§	**(Jointly Administered)**
	§	

ORDER GRANTING MOTION OF TRACO INTERNATIONAL GROUP S. DE R.L. (I) COMPELLING PAYMENT BY DEBTORS OF PREMIUMS DUE UNDER INSURANCE POLICIES; (II) COMPELLING PAYMENT OF PREPETITION SETTLEMENT AND DEFENSE COSTS IN COMPLIANCE WITH PREVIOUSLY ENTERED ORDERS; (III) COMPELLING ASSUMPTION OR REJECTION OF INSURANCE POLICIES; (IV) LIFTING AUTOMATIC STAY TO PERMIT THE CANCELLATION OF INSURANCE POLICIES; (V) COMPELLING THE RETURN OF TRACO FUNDS HELD BY THE DEBTORS; AND (VI) GRANTING RELATED RELIEF
[Docket No.]

On December 2, 2024, TRACO International Group S. De R.L. ("TRACO") filed its *M t ter at al r . . . ell a e t e t r re e der ra e l e ell a e t re et t ettle e t a d e e e t l a e t re l tered rder ell t r e e t ra e l e t t at ta t er t t e a ellat ra e l e ell t e et r d eld t e e t r a d ra t elated el e* . The Court finds and concludes that the motion has merit and should be GRANTED.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

TRACO is granted a priority postpetition administrative claim for the unpaid premiums in the amount of $35.5 million as of October 31, 2024 and the unpaid settlement and defense costs in the amount of $1.3 million pursuant to Sections 503(b)(1)(A) and 507(a)(2) of the Bankruptcy Code, B.L.R. 4002-1, and applicable law, and therefore, the Debtors are directed to make payment to TRACO in the amount of at least $36.8 million within ten (10) days from entry of this order;

If the Debtors are unwilling to pay TRACO for the 2024 premiums due under the Insurance Policies, TRACO must either assume or reject the Insurance Policies in writing within ten (10) days from entry of this order. To the extent that the Debtors elect to assume the Insurance Policies, the Debtors must promptly cure all defaults – including, but not limited to, paying all outstanding premiums;

If the Debtors fail to pay TRACO at least $36.8 million within ten (10) days for entry of this Order, as set forth above, the automatic stay is lifted to permit TRACO to take any and all actions to terminate the 2024 Insurance Policies as to the Debtors and their hospitals;

The 14-day say of the effectiveness of this Order is hereby waiver; and

The Debtors shall immediately pay TRACO (i) $72 million for TRACO's prepetition funds held by the Debtors; and (ii) the portion of the sale proceeds from Odessa to which TRACO is entitled following an appropriate allocation.

Signed: , 2024

Christopher Lopez
United States Bankruptcy Judge

Order prepared by:

Timothy Walsh (admitted pro hac vice)
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Counsel for TRACO International
Group S. De R.L.

EXHIBIT B

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re: STEWARD HEALTH CARE SYSTEM LLC, *et al.*, Debtors.[1]	Chapter 11 Case Nos. 24-90213 (CML) (Jointly Administered)
TRACO INTERNATIONAL GROUP S. DE R.L., Plaintiff, v. STEWARD HEALTH CARE SYSTEM LLC AND ALL AFFILIATED DEBTORS. Defendants.	Adv. Pro. No.

COMPLAINT

TRACO International Group S. De R.L. ("TRACO"), affiliated entity and counterparty to various insurance policies (the "Insurance Policies") with Steward Health Care System LLC and its debtor affiliates in these Chapter 11 cases (collectively, the "Debtors") files this this *Complaint* (this "Complaint") against the Debtors, and alleges, as follows:

JURISDICTION & VENUE

1. This Court has subject matter jurisdiction over this adversary proceeding pursuant to 28 U.S.C. section 1334. This matter is a core proceeding pursuant to 28 U.S.C. sections 157(b)(2)(O). This adversary proceeding arises in, arises under, and relates to the underlying

bankruptcy case under title 11 of the United States Code (the "Bankruptcy Code").

2. TRACO confirms its consent, pursuant to Rule 7008 of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules") and Rule 7008-1 of the Bankruptcy Local Rules for the Southern District of Texas (the "Bankruptcy Local Rules"), to the entry of a final order or judgment consistent with Article III of the United States Constitution.

3. Venue is proper in this Court pursuant to 28 U.S.C. sections 1408 and 1409.

PARTIES

4. Plaintiff TRACO International Group S. De R.L. ("TRACO") is the counterparty to various insurance policies with the Debtors including medical malpractice insurance coverage for the Debtors' hospitals and the doctors and other health care professionals (the "Insurance Policies").

5. TRACO is also a non-debtor affiliate and subsidiary of the Debtors.

6. Defendants are the Debtors, who are counterparties to the Insurance Policies.

GENERAL BACKGROUND

7. On May 6, 2024, (the "Petition Date"), the Debtors each commenced with this Court a voluntary case under chapter 11 of title 11 of the United States Code (the "Bankruptcy Code"). The Debtors are authorized to continue to operate their business and manage their properties as debtors in possession pursuant to sections 1107(a) and 1108 of the Bankruptcy Code. No trustee or examiner has been appointed in these chapter 11 cases.

8. On May 16, 2024, the U.S. Trustee appointed the Official Committee of Unsecured Creditors (the "Committee") pursuant to section 1102 of the Bankruptcy Code.

9. As set forth in the First Day Declaration (defined below), as of the Petition Date, the Debtors owned and operated the largest private physician-owned for-profit healthcare network in the United States. Headquartered in Dallas, Texas, the Debtors' operations included 31 hospitals across eight states, approximately 400 facility locations, 4,500 primary and specialty care physicians, 3,600 staffed beds, and a company-wide workforce of nearly 30,000 employees. The

Debtors provided care to more than two million patients annually.

10. Additional information, as of the Petition Date, regarding the Debtors' business, capital structure, and the circumstances leading to the commencement of these chapter 11 cases is set forth in the Declaration of John R. Castellano in Support of Debtors' Chapter 11 Petitions and First-Day Pleadings [Docket No. 38] (the "First Day Declaration").

FACTUAL BACKGROUND

A. TRACO'S RELATIONSHIP WITH THE DEBTORS

11. Prior to the Petition Date and through the present, TRACO, a non-debtor affiliate and subsidiary of the Debtors, has provided insurance coverage, including malpractice coverage, comprehensive general liability coverage, workers' compensation coverage, employer liability coverage, stop-loss coverage, and certain excess liability coverage to the Debtors and certain of their non-Debtor affiliates pursuant to the Insurance Policies.

12. Specifically, TRACO provides medical malpractice coverage to approximately 1,400 medical practitioners, including approximately 1,200 physicians who were employed by the Debtors and approximately 200 physicians who are in private practice and are affiliated with the Debtors. TRACO does not provide insurance coverage to any entities or individuals, other than the Debtors and the Debtors' hospitals, non-Debtor affiliates, employed physicians, and affiliated physicians and their employers.

13. TRACO contracts directly or indirectly (at TRACO's expense) with service providers, such as third-party administrators, managers, legal advisors, and various consultants (including actuarial consultants, tax advisors, investment managers, compliance officers, and auditors) to manage and administer the various coverages for its members. TRACO, through its third-party administrators, also retains defense counsel to defend against claims covered by its policies, including medical malpractice claims.

14. The aggregate insurance premiums payable to TRACO are approximately $3.5 million per month.

15. Notwithstanding entry of Orders authorizing the payment of the insurance premiums (as discussed below), as well as the inclusion of funds in the Budget to pay TRACO for premiums and other obligations (both prepetition and postpetition) due under the Insurance Policies, as of October 31, 2024, the Debtors have failed to pay any of the premiums due under the Insurance Policies for 2024. See Docket Nos. 116, 611, and 2166.

B. TRACO'S ORDINARY COURSE OF BUSINESS

16. Immediately prior to the Petition Date, the Debtors did not pay the premiums due under the Insurance Policies in cash. Rather, the premiums were made through a system of intercompany transactions by which the Debtors booked the premiums as being payables owed to TRACO. The costs of the services that TRACO provided were then paid directly by Debtor Steward Health Care System LLC ("SHC") on behalf of TRACO. These payments were made at the direction of TRACO, with SHC acting in an administrative capacity only and having no ability to refuse a direction by TRACO. Such payments resulted in intercompany payables being owed by TRACO to SHC. Pursuant to this system, any payments covered by the TRACO policies, including defense costs and settlement payments, were paid directly by SHC, and such payments resulted in intercompany payables being owed by TRACO to SHC and set off against the premiums due.

17. Prior to 2021, however, the Debtors paid TRACO the monthly premiums due and owing under the relevant insurance policies in cash. The switch to intercompany transactions was done as an accommodation to the Debtors at a time when they were in a transition period with respect to the hospitals.

C. THE INSURANCE MOTION.

18. On May 6, 2024, the Debtors filed a motion seeking authorization to continue insurance policies [Docket No. 6] (the "Insurance Motion"). See Docket No. 6 ¶ 26.

19. The Insurance Motion was approved by interim Order [Docket No. 116] (the "Interim Order") on May 7, 2024. The Interim Order approved the payment of premiums to

TRACO and authorized the continuance of the Debtors' "Captive Insurer Program in the ordinary course and to honor any prepetition and postpetition amounts to TRACO to ensure uninterrupted coverage under their Insurance Policies." Insurance Motion at ¶ 6.

20. This Court subsequently entered a second interim Order [Docket No. 611] (the "Second Order") with respect to the Insurance Motion, authorizing the Debtors to continue their Captive Insurer Program in the ordinary course and pay all obligations under the Insurance Policies, whether incurred before or after the Petition Date, including making payments on behalf of TRACO, while noting that any non-ordinary course payments to be made on behalf of TRACO shall not be made under the authority solely provided by the Second Interim Order. See Docket No. 611 at ¶ 7.

21. Finally, on August 23, 2024, the Court entered a final Order [Docket No. 2166] (the "Final Order" and, collectively with the Interim Order and the Second Order, the "Insurance Orders") again authorizing the Debtors to "pay any prepetition and postpetition amounts owed" (Final Order at ¶ 1) and continue the Captive Insurer Program "including making payments on behalf of TRACO to honor postpetition obligations under the Captive Insurer Program and any prepetition obligations owed to defense counsel under the Captive Insurer Program up to an aggregate amount of $3.4 million (such amount subject to increase with the consent of the Creditors' Committee or further order of the Court)…" Final Order at ¶ 7. The Final Order further provides that "any cost of defending a Covered Physician against a Covered Claim covered by, and in accordance with the terms of, the Captive Insurer Program ('Defense Costs'), shall be accorded administrative expense priority status in accordance with section 503(b) of the Bankruptcy Code up to the amount of coverage available to the Covered Physician for such Covered Claim and Defense Costs under the Captive Insurer Program." Id.

22. Following entry of the Insurance Orders, TRACO repeatedly requested payment of the authorized amounts, as well as an increase in the approved funding, and have faced either denials or delays from the Debtors.

23. Based on information and belief, TRACO understood that certain funds, as approved by the Insurance Orders, were being held by the Debtors for payments on behalf of TRACO. TRACO understands that the Debtors are currently depositing $1.25 million a month in an account at Kroll for payment of postpetition medical malpractice claims asserted against physicians. See Supplement to Final Cash Management Order and Rule 2015.3 Disclosure (the "Supplemental Rule 2015.3 Disclosure"), Docket 1956, p. 3. Notwithstanding the entry of the Court Orders authorizing the use of these funds, the Debtors have repeatedly refused to utilize these funds to make payments as requested by TRACO.

24. On June 3, 2024, the Court approved an Order regarding postpetition financing, including a budget agreed to by the Debtors and the Committee (as amended from time to time, the "Budget"). See Docket No. 625. Subsequently, on July 10, 2024, the Court approved a second Order regarding postpetition financing. See Docket No. 1538. Pursuant to the Budget agreed to by the Debtors, the secured lenders, and the UCC, the Debtors allocated $3.4 million for payment to TRACO on account of prepetition obligations due pursuant to the Insurance Policies. In addition, despite the Budget providing for the payment of premiums in the ordinary course of the Debtors' business, the monthly premiums have not been paid.

25. On August 13, 2024, the Debtors filed a Supplemental Rule 2015.3 Disclosure which stated, in relevant part: "[t]he Debtors have consulted with their healthcare and regulatory counsel, McDermott Will & Emory LLP, and the Panama captive insurance counsel. The Debtors believe that medical malpractice coverage provided under the Captive Insurance Program has been and continues to remain in full force and effect and that the Debtors have been and remain in compliance with all legal requirements necessary to maintain the Captive Insurance Program." Supplemental Rule 2015.3 Disclosure, Dkt. 1956, p. 5, paragraph 7.

D. THE SALE OF DAVIS.

26. In approximately 2022, TRACO purchased $132 million of shares in Davis Hospital & Medical Center LP ("Davis Hospital"). Following this purchase, TRACO owned equity

of approximately 30.18% in Davis Hospital.

27. On or about February 15, 2023, Davis Hospital entered into a sale transaction with Catholic Health Initiatives Colorado ("Buyer") for the sale of various hospital facilities owed by Davis Hospital (the "Davis Sale"). The sale price was $685 million, with some adjustments.

28. Of this sale price, $72 million in proceeds were allocated to TRACO (the "TRACO Sales Proceeds") as a return on TRACO's equity investment.

29. However, as was the practice of TRACO and the Debtors at the time, the Debtors continued to hold these funds for TRACO's benefit.

30. At all relevant times, the TRACO Sales Proceeds were the property of TRACO. The TRACO Sales Proceeds were not, and never were, property of the Debtors or property of the Debtors' estates.

31. TRACO did not allow those proceeds to be pledged in connection with any subsequent transaction. TRACO is not aware whether the Debtors have attempted to pledge those funds to any other lender.

32. Upon information and belief, the Debtors never reported the TRACO Sales Proceeds to the IRS as income of the Debtors.

33. TRACO is now demanding the return of the TRACO Sales Proceeds but, despite multiple conversations with the Debtors and their counsel, the TRACO Sales Proceeds have not been returned.

E. THE ODESSA SALE.

34. On or around October 11, 2024, this Court approved the sale (the "Odessa Sale") of Odessa Regional Hospital LP ("Odessa"). See Docket No. 2887.

35. The Debtors have not provided TRACO with an allocation regarding the proceeds from this sale, if any, that will remain following the payment of applicable debt.

36. Upon this allocation being done, TRACO is entitled to payment of the funds owing to TRACO as a non-debtor, 12.36% owner of Odessa (the "Odessa Proceeds").

37. At all relevant times, the Odessa Proceeds were the property of TRACO. The Odessa Proceeds were not, and never were, property of the Debtors or property of the Debtors' estates.

38. Following the completion of an accounting, TRACO demands the return of the Odessa Proceeds.

F. THE DEBTORS ARE IN DEFAULT UNDER THE INSURANCE POLICIES

39. The Debtors are in default under the Insurance Policies.

40. On December 2, 2024, TRACO filed a motion seeking payment of premiums due and owing under the Insurance Policies, as well as requesting certain other relief, including the return of the TRACO Sales Proceeds. See Docket No. 3341.

CAUSES OF ACTION

COUNT I: BREACH OF FIDUCIARY DUTY

41. TRACO hereby incorporates all of the foregoing and ensuing allegations as if fully set forth herein.

42. Whether an asset is property of a bankruptcy estate is governed by 11 U.S.C. section 541. Section 541(d) states that:

> Property in which the debtor holds, as of the commencement of the case, only legal title and not an equitable interest, such as a mortgage secured by real property, or an interest in such a mortgage, sold by the debtor but as to which the debtor retains legal title to service or supervise the servicing of such mortgage or interest, becomes property of the estate under subsection (a)(1) or (2) of this section only to the extent of the debtor's legal title to such property, but not to the extent of any equitable interest in such property that the debtor does not hold.

11 U.S.C. § 541(d).

43. The Davis Sale was governed by Delaware Law. Under Delaware law, a fiduciary relationship may be established when one party holds funds for another, thereby obligating the holder to act in the best interest of the beneficiary. A fiduciary relationship exists where, such as here, a special duty exists on the part of one person to protect the interests of another. *See, e.g., WP Devon Asssocs., L.P. v. Hartstrings, LLC*, No. CIV.A. N11C-02216JRJ, 2012 WL 3060513,

at *4 (Del. Super. Ct. July 26, 2012) ("Fiduciary relationships exist when one person has reposed a special confidence in another to the extent that the parties do not deal with each other on equal terms, either because of an overmastering dominance on one side or weakness, dependence or justifiable trust, on the other."); *see also Kinzbach Tool Co. v. Corbett-Wallace Corp.*, 160 S.W.2d 509, 513 (Tex. 1942) ("[t]he term 'fiduciary' applies to any person who occupies a position of peculiar confidence towards another.").

44. In this case, the Debtors held the TRACO Sales Proceeds for the benefit of TRACO, based on the ordinary course practice of the Parties in 2023. As fiduciaries, the Debtors had a duty to act in the best interest of TRACO concerning these funds. The Debtors' failure to remit the TRACO Sales Proceeds constitutes a breach of this duty.

45. The TRACO Sales Proceeds are the sole and exclusive property of TRACO, and neither the Debtors nor their estates have an interest in this property.

46. The Debtors have failed to remit the TRACO Sales Proceeds to TRACO even though these funds belong to TRACO and are not property of the Debtors' estates.

47. Accordingly, TRACO is entitled to turnover of the TRACO Sales Proceeds, which are held by the Debtors in constructive trust and are not property of the Debtors' estates. Under Delaware law,"[a]lthough a constructive trust typically is imposed when the defendant wrongfully obtains specific property or identifiable proceeds of specific property from the plaintiff, this equitable remedy also can be applied to the recovery of money when the right asserted by the plaintiff is distinctly equitable in nature, including a right arising from breach of a fiduciary duty. *Standard Chlorine of Delaware, Inc. v. Sinibaldi*, 821 F.Supp. 232, 254 (D. Del. 1992); *see also In re Ward*, 558 B.R. 771, 789-90 (Bankr. N.D. Tex. 2016), *quoting In re Haber Oil Co., Inc.*, 12 F.3d 426, 436 (5th Cir. 1994) (a constructive trust is "an equitable remedy imposed by law to prevent unjust enrichment resulting from an unconscionable act.").

COUNT III: REQUEST FOR ACCOUNTING

48. TRACO hereby incorporates all of the foregoing and ensuing allegations as if fully

set forth herein.

49. The Odessa Sale is governed by Delaware law.

50. As an equity holder in Odessa, TRACO is entitled to a share of any proceeds from the Odessa Sale following the payment of creditors. TRACO hereby requests an accounting of the proceeds from the Odessa Sale.

51. Any funds allocated to TRACO through this accounting are not property of the Debtors' estates and are held by the Debtors on TRACO's behalf.

52. Following such accounting, the Debtors must turn over such funds to TRACO immediately.

RESERVATION

53. TRACO reserves the right to amend this Complaint for any reason, including but not limited to addressing the handling of the funds from the Odessa Sale following the receipt of a proper accounting.

PRAYER

WHEREFORE, based on the foregoing, the Trustee respectfully requests that, after a determination on the merits, this Court enter an order:

A. Requiring the Debtors to, at their sole cost and expense, turn over and deliver the TRACO Sales Proceeds to TRACO;

B. Requiring an accounting of the proceeds of the Odessa Sale and, if appropriate, turnover of proceeds from the Odessa Sale that are TRACO's property;

C. Requiring the Debtors to, at their sole cost and expense, turn over and deliver the Odessa Proceeds to TRACO;

D. Awarding pre- and post-judgment interest on the foregoing judgment amounts; and

E. Granting TRACO such other and further relief to which it may be justly entitled.

DATED: December 6, 2024

Respectfully submitted,

STEPTOE LLP

By: */s/ Timothy Walsh*
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Counsel for TRACO International Group S. De R.L.

B1040 (FORM 1040) (12/24)

ADVERSARY PROCEEDING COVER SHEET (Instructions on Reverse)	**ADVERSARY PROCEEDING NUMBER** (Court Use Only)
PLAINTIFFS TRACO International Group S. De R.L.	**DEFENDANTS** STEWARD HEALTH CARE SYSTEM LLC and all affiliated debtors
ATTORNEYS (Firm Name, Address, and Telephone No.) Steptoe LLP, Attn: Timothy Walsh, 1114 Ave. of the Am., New York, NY 10036, Tel: 212-957-3085	**ATTORNEYS** (If Known) Weil, Gotshal & Manges LLP, Attn: Clifford Carlson, 767 Fifth Ave, New York, NY 10153; Tel: 212-310-8000
PARTY (Check One Box Only) □ Debtor □ U.S. Trustee/Bankruptcy Admin x Creditor □ Other □ Trustee	**PARTY** (Check One Box Only) x Debtor □ U.S. Trustee/Bankruptcy Admin □ Creditor □ Other □ Trustee

CAUSE OF ACTION (WRITE A BRIEF STATEMENT OF CAUSE OF ACTION, INCLUDING ALL U.S. STATUTES INVOLVED)
Plaintiff seeks turnover of property belonging to Plaintiff that is in the possession of the Debtors, including but not limited to cash resulting from the 2023 sale of Plaintiff's interest in Davis Hospital & Medical Center LP. Plaintiff also seeks an accounting of the sale of Odessa Regional Hospital LP and turnover of the proceeds from the sale to which Plaintiff is entitled as partial owner of Odessa.

NATURE OF SUIT

(Number up to five (5) boxes starting with lead cause of action as 1, first alternative cause as 2, second alternative cause as 3, etc.)

FRBP 7001(a) – Recovery of Money/Property
- ☐ 11-Recovery of money/property - §542 turnover of property
- ☐ 12-Recovery of money/property - §547 preference
- ☐ 13-Recovery of money/property - §548 fraudulent transfer
- X X 14-Recovery of money/property - other

FRBP 7001(b) – Validity, Priority or Extent of Lien
- ☐ 21-Validity, priority or extent of lien or other interest in property

FRBP 7001(c) – Approval of Sale of Property
- ☐ 31-Approval of sale of property of estate and of a co-owner - §363(h)

FRBP 7001(d) – Objection/Revocation of Discharge
- ☐ 41-Objection / revocation of discharge - §727(c),(d),(e)

FRBP 7001(e) – Revocation of Confirmation
- ☐ 51-Revocation of confirmation

FRBP 7001(f) – Dischargeability
- ☐ 66-Dischargeability - §523(a)(1),(14),(14A) priority tax claims
- ☐ 62-Dischargeability - §523(a)(2), false pretenses, false representation, actual fraud
- ☐ 67-Dischargeability - §523(a)(4), fraud as fiduciary, embezzlement, larceny

(continued next column)

FRBP 7001(f) – Dischargeability (continued)
- ☐ 61-Dischargeability - §523(a)(5), domestic support
- ☐ 68-Dischargeability - §523(a)(6), willful and malicious injury
- ☐ 63-Dischargeability - §523(a)(8), student loan
- ☐ 64-Dischargeability - §523(a)(15), divorce or separation obligation (other than domestic support)
- ☐ 65-Dischargeability - other

FRBP 7001(g) – Injunctive Relief
- ☐ 71-Injunctive relief – imposition of stay
- ☐ 72-Injunctive relief – other

FRBP 7001(h) Subordination of Claim or Interest
- ☐ 81-Subordination of claim or interest

FRBP 7001(i) Declaratory Judgment
- ☐ 91-Declaratory judgment

FRBP 7001(j) Determination of Removed Action
- ☐ 01-Determination of removed claim or cause

Other
- XX SS-SIPA Case – 15 U.S.C. §§78aaa *et.seq.*
- 02-Other (e.g. other actions that would have been brought in state court if unrelated to bankruptcy case)

X Check if this case involves a substantive issue of state law	□ Check if this is asserted to be a class action under FRCP 23
□ Check if a jury trial is demanded in complaint	Demand No less than $72 Million

Other Relief Sought
Request for an accounting

B1040 (FORM 1040) (12/24)

BANKRUPTCY CASE IN WHICH THIS ADVERSARY PROCEEDING ARISES		
NAME OF DEBTOR Steward Health Care System LLC et al.	BANKRUPTCY CASE NO. Case No. 24-90213	
DISTRICT IN WHICH CASE IS PENDING Southern District of Texas Bankruptcy Court	DIVISION OFFICE Houston	NAME OF JUDGE Christopher M. Lopez
RELATED ADVERSARY PROCEEDING (IF ANY)		
PLAINTIFF	DEFENDANT	ADVERSARY PROCEEDING NO.
DISTRICT IN WHICH ADVERSARY IS PENDING	DIVISION OFFICE	NAME OF JUDGE
SIGNATURE OF ATTORNEY (OR PLAINTIFF)		
DATE	PRINT NAME OF ATTORNEY (OR PLAINTIFF)	

INSTRUCTIONS

The filing of a bankruptcy case creates an "estate" under the jurisdiction of the bankruptcy court which consists of all of the property of the debtor, wherever that property is located. Because the bankruptcy estate is so extensive and the jurisdiction of the court so broad, there may be lawsuits over the property or property rights of the estate. There also may be lawsuits concerning the debtor's discharge. If such a lawsuit is filed in a bankruptcy court, it is called an adversary proceeding.

A party filing an adversary proceeding must also complete and file Form 1040, the Adversary Proceeding Cover Sheet, unless the party files the adversary proceeding electronically through the court's Case Management/Electronic Case Filing system (CM/ECF). (CM/ECF captures the information on Form 1040 as part of the filing process.) When completed, the cover sheet summarizes basic information on the adversary proceeding. The clerk of court needs the information to process the adversary proceeding and prepare required statistical reports on court activity.

The cover sheet and the information contained on it do not replace or supplement the filing and service of pleadings or other papers as required by law, the Bankruptcy Rules, or the local rules of court. The cover sheet, which is largely self-explanatory, must be completed by the plaintiff's attorney (or by the plaintiff if the plaintiff is not represented by an attorney). A separate cover sheet must be submitted to the clerk for each complaint filed.

Plaintiffs and **Defendants.** Give the names of the plaintiffs and defendants exactly as they appear on the complaint.

Attorneys. Give the names and addresses of the attorneys, if known.

Party. Check the most appropriate box in the first column for the plaintiffs and the second column for the defendants.

Demand. Enter the dollar amount being demanded in the complaint.

Signature. This cover sheet must be signed by the attorney of record in the box on the second page of the form. If the plaintiff is represented by a law firm, a member of the firm must sign. If the plaintiff is pro se, that is, not represented by an attorney, the plaintiff must sign.

EXHIBIT C

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	§	**Chapter 11**
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	§	**Case No. 24-90213 (CML)**
Debtors.[1]	§	**(Jointly Administered)**

JOINT CHAPTER 11 PLAN OF LIQUIDATION OF STEWARD HEALTH CARE SYSTEM LLC AND ITS AFFILIATED DEBTORS

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Attorneys for Debtors and Debtors in Possession

July 11, 2025
Houston, Texas

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 2811 McKinney Avenue, Suite 300, Dallas, Texas 75204.

Schedule 1-B

Preference Defendants

TORNIER INC
TOWNE PARK LLC
TRANE US INC
UNUM LIFE INSURANCE COMPANY OF
UROLOGIC SURGEONS OF ARIZONA PLC
US FOODS INC
US MED EQUIP LLC
WASTE CONNECTIONS OF FLORIDA
WEST TECHS CHILL WATER SPECIALIST
WESTPORT LINEN SERVICES INC
WHITMAN PARTNERS INC
WICKER SMITH O'HARA MCCOY & FORD
WLG WL GORE&ASSOC MPD
WOLF & COMPANY PC
WRIGHT MEDICAL TECHNOLOGY INC
3M HEALTH INFORMATION SYSTEMS
ACCLARA SOLUTIONS LLC
CLOUDMED
COGNIZANT TECHNOLOGY SOLUTIONS
CONSENSUS CLOUD SOLUTIONS
DELL FINANCIAL SERVICES
ERGONOMIC GROUP
HEWLETT PACKARD FINANCIAL SERVICES
HP INC
INOVALON PROVIDER INC
INTERLACE HEALTH LLC
IODINE SOFTWARE LLC
JAMS INC
LOGIXHEALTH INC
MRO CORPORATION
PRESIDIO NETWORKED
REVSPRING INC
TEGRIA RCM GROUP US INC.
BREAZEALE SACHSE & WILSON LLP
BRUCE & KELLEY PC
CAPPLIS CONNORS CARROLL & ENNIS
DRAFFIN & TUCKER LLP
FALK WAAS HERNANDEZ ET AL
FOSTER & ELDRIDGE LLP
HALL PRANGLE & SCHOONVELD LLC
HAMEL MARCIN DUNN REARDON & SHEA PC

EXHIBIT D

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

IN RE:	§	
	§	**CASE NO. 24-90213**
STEWARD HEALTH CARE SYSTEM, LLC.,[1]	§	
	§	**CHAPTER 11**
	§	
DEBTORS.	§	

UNITED STATES TRUSTEE'S EXPEDITED MOTION TO DISMISS OR CONVERT PURSUANT TO 11 U.S.C. § 1112(B)

This motion seeks an order that may adversely affect you. If you oppose the motion, you should immediately contact the moving party to resolve the dispute. If you and the moving party cannot agree, you must file a response and send a copy to the moving party. You must file and serve your response within 21 days of the date this was served on you. Your response must state why the motion should not be granted. If you do not file a timely response, the relief may be granted without further notice to you. If you oppose the motion and have not reached an agreement, you must attend the hearing. Unless the parties agree otherwise, the court may consider evidence at the hearing and may decide the motion at the hearing.

Represented parties should act through their attorney.

Expedited relief has been requested. If the Court considers the motion on an expedited basis, then you will have less than 21 days to answer. If you object to the requested relief or if you believe that the expedited consideration is not warranted, you should file an immediate response.

EXPEDITED RELIEF IS REQUESTED NOT LATER THAN MAY 29, 2025, at 10:30 A.M CENTRAL STANDARD TIME.

TO THE HONORABLE CHRISTOPHER M. LOPEZ
UNITED STATES BANKRUPTCY JUDGE:

Kevin M. Epstein, the United States Trustee for the Southern District of Texas (the "U.S. Trustee"), moves for an order converting the above captioned Chapter 11 cases for "cause," or in

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201

the alternative, dismissing these cases to Chapter 7 under 11 U.S.C. § 1112(b). In support of his request, the U.S. Trustee states as follows:

I. INTRODUCTION

1. Cause exists to convert or dismiss these cases because they are administratively insolvent with no realistic path towards a confirmable plan of reorganization. Ordinary and operational administrative claimants, many of whom provided post-petition life-saving supplies and services to the Debtors, have not been paid. The administrative burn rate is exorbitant and unsustainable, with expenses continuing to accrue daily. The latest fee statement from the Debtors' lead bankruptcy attorneys evidences that attorneys' fees and expenses of approximately $85,000,000 have accrued, as of January 31, 2025.[2] Upon information and belief, the professional fees as of the date of this motion, for primary counsel alone, are north of $100 million. Although the Debtors have made meaningful progress since the petition date, at this juncture, there is little remaining benefit to stakeholders in the continued administration of these Chapter 11 cases because the Debtors cannot pay the estimated $127 million in administrative claims on the effective date. Proceeding with a contested and expensive confirmation process for a facially unconfirmable plan would only further burden the estate with significant unrecoverable costs. The Debtors' estates simply cannot afford this unnecessary financial gamble.

2. The Debtors are seeking to exit these bankruptcy cases with a plan that violates the Bankruptcy Code. A fundamental tenet of bankruptcy law is that administrative creditors are entitled to the highest priority of payment. *See* 11 U.S.C. § 1129(a)(9). A plan cannot be confirmed unless all administrative expenses are paid in full on the effective date. This is a core promise of

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[2] *See Summary Coversheet to Third Interim Fee Application of Weil, Gotshal & Manges LLP, Attorney for Debtors, for the Period from November 1, 2024, Through and Including January 31, 2025*. ECF 4254.

the bankruptcy system—administrative claimants who continue to provide goods and services to a debtor after the bankruptcy filing will be paid in full for those goods or services. Here, the Debtors concede in the Disclosure Statement that they cannot pay their administrative claims but suggest an alternative mechanism that does not comply with the Bankruptcy Code.

3. The Administrative Expense Claims Consent Program forces *certain* administrative claimants to accept less than payment in full. Reliance on such mechanism in a chapter 11 case is flawed and impermissible because a chapter 11 plan cannot force administrative claimants to accept lesser terms. A mechanism of forced consent to accept lesser terms is not supported by the Bankruptcy Code or applicable law. The Court should reject the notion that certain administrative expenses are of lesser importance and do not have to be paid in full. Permitting the Debtors to sidestep their obligation to pay the ordinary administrative claimants in full, many of whom faithfully provided post-petition goods and services that ensured the safety of patients and the Debtors' continued operations during these cases, while allowing professionals to be paid in full undermines the integrity of the bankruptcy system. If this Court authorizes this mechanism, ordinary administrative claimants in future cases—many of whom provide essential goods and services to debtors in bankruptcy—will think twice before providing services or supplies to debtors. The approval of this ill-advised mechanism could have a chilling effect on future chapter 11 cases, jeopardize the ability of future debtors to obtain post-petition goods and services and successfully reorganize. In the healthcare context, this could lead to disastrous results given that uninterrupted services and the safety of patients are paramount concerns when a case is filed.

4. For these reasons, the Court should convert or dismiss these cases particularly given that the Debtors' Disclosure Statement demonstrates that these cases are administratively insolvent, and the Debtors cannot pay the administrative expenses in full by the effective date.

II. JURISDICTION

5. This is a core proceeding concerning the administration of the estate pursuant to 28 U.S.C. § 157(b)(2)(A) which this Court may hear and determine pursuant to IOP 15(A) and LR 40.3.1 of the U.S. District Court for the Southern District of Texas.

6. Venue in this district appears proper pursuant to 28 U.S.C. §§ 1408 and 1409.

7. The U.S. Trustee has standing to request dismissal or conversion under 11 U.S.C. § 307 and 28 U.S.C. § 586(a)(3).

III. FACTUAL SUMMARY

8. On May 6, 2024, the Debtors filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. The cases are jointly administered.

9. The Debtors are authorized to continue to operate their businesses and manage their properties as debtors-in-possession pursuant to §§ 1107(a) and 1108 of the Bankruptcy Code.

10. On April 28, 2025, the Debtors filed the Plan, Disclosure Statement, and the Solicitation Motion. ECF Nos. 4743, 4744, and 4745, respectively.

11. The Disclosure Statement disclosed that 2,803 administrative claims were filed with the Court asserting an astounding $102.86 ***billion*** in administrative expenses. *See* ECF No. 4744, Section IV.R Although many of the motions requesting administrative expenses have not been adjudicated, the Debtors assert that "the responsibility of the Debtors is approximately $127 million, including up to approximately $13 million in 503(b)(9) claims, approximately $103 million of accounts payable claims, and approximately $12 million in other claims (including employee, litigation, regulatory, insurance, tax, and real estate claims)." *Id.* Although recognizing that there are $127 million in administrative expense claims, the Debtors have yet to set aside that amount to ensure that administrative expenses are paid in full by the effective date.

12. Article 1 of the Plan at 1.1 defines Administrative Expense Claim to mean "any Claim for a cost or expense of administration incurred during the Chapter 11 Cases of a kind specified under sections 327, 328, 330, 365, 503(b) of the Bankruptcy Code and entitled to priority under sections 507(a)(2), 507(b), or 1114(e)(2) of the Bankruptcy Code, including (i) the actual and necessary costs and expenses incurred on or after the Petition Date and through the Effective Date of preserving the Estates and operating the Debtors' businesses and (ii) Professional Fee Claims, but excluding FILO DIP Claims, FILO Bridge Claims, Intercompany Claims, and Priority Tax Claims." ECF No. 4743.

13. In the Plan, the Debtors do not propose to pay administrative claims in full as required by the Bankruptcy Code. Instead, the Debtors devised an "Administrative Claims Consent Program," that requires ordinary administrative claimants to reduce their allowed claims by 50% reduction and thereafter share $12.5 million pro rata. Notably, Professional Fee Claims and FILO DIP Claims which should be treated similarly are excluded from the Administrative Claims Consent Program, and Professional Fee Claims "Shall be paid in full in Cash in such amounts as are Allowed by the Bankruptcy Court . . . ." Plan, Art. II.2.3.a. The Debtors also propose to send ordinary administrative claimants opt out forms so that claimants who "do not timely, properly, and affirmatively opt-out" will be deemed to have agreed to the terms of the Administrative Expenses Claims Consent Program. ECF No. 4744, Section I.B.

14. The Debtors' Plan also imposes a "Minimum Participation Threshold" on administrative claimants. The Disclosure Statement explains that "If Holders of more than 25% (in dollar amount) of the Debtors' estimated Allowed Administrative Expense Claims opt-out of the Administrative Expense Claims Consent Program, and unless such condition is waived by the Debtors and the Creditors' Committee, the Administrative Expense Claims Consent Program will

not be consummated." ECF 4744, Section I.B. The Disclosure Statement does not provide whether the Plan would be confirmable if more than 25% holder of administrative claimants opted out of the Administrative Expense Claims Consent Program.

IV. ARGUMENT

A. Cause exists to dismiss or convert these cases because the Debtors are administratively insolvent.

15. In relevant part, Section 1112(b) of the Bankruptcy Code provides that on the request of a party in interest, and after notice and a hearing, the court shall convert the case to Chapter 7 or dismiss the case, whichever is in the best interests of creditors of the estate, so long as the movant establishes "cause." *See* 11 U.S.C. § 1112(b)(1).

16. Section 1112(b)(4) sets forth a list of sixteen grounds that constitute "cause" for conversion or dismissal. *See* 11 U.S.C. § 1112(b)(4)(A)-(P). This list is not exhaustive, and a case may be dismissed or converted for causes other than those specifically identified in section 1112(b)(4). *See In re TMT Procurement Corp.*, 534 B.R. 912, 917 (Bankr. S.D. Tex. 2015); *In Re Zamora-Quezada*, 622 B.R. 865, 879, 886 (Bankr. S.D. Tex. 2017).

17. The Court shall dismiss a case for "cause" if the Court finds that there is a "substantial or continuing loss to or diminution of the estate and the absence of a reasonable likelihood of rehabilitation." 11 U.S.C. § 1112(b)(4)(A); *In re Ford Steel, LLC*, 629 B.R. 871, 879-80 (Bankr. S.D. Tex. 2021). There are two elements to consider under Section 1112(b)(4)(A): (i) a "substantial or continuing loss to or diminution of the estate," and (ii) the "absence of a reasonable likelihood of rehabilitation." *See* 11 U.S.C. § 1112(b)(4)(A). Both elements are present in these cases.

18. With respect to substantial or continuing loss to or diminution of the estate, Courts routinely held that a "[n]egative cash flow and an inability to pay current expenses as they come

due can satisfy the continuing loss or diminution of the estate standard for purposes of § 1112(b)." *See In re TMT Procurement Corp.*, 534 B.R. 912, 919 (Bankr. S.D. Tex. 2015) (citing *Nester v. Gateway Access Sols., Inc. (In re Gateway Access Sols., Inc.)*, 374 B.R. 556, 564 (Bankr. M.D. Pa. 2007)). "Negative cash flow means that the estate's current liabilities are increasing more rapidly than cash is available to pay as due." 7 *Collier on Bankruptcy* ¶ 1112.04[6][a] (Alan N. Resnick & Henry J. Sommer eds., 16th ed.).

19. In these cases, there is a continuing loss and diminution of the Debtors' estates because administrative expenses continue to accrue, and the Disclosure Statement discloses that the Debtors have no means to pay administrative claims in full, whether they are $102 billion or the Debtors' optimistic assertion that they could be reduced to $127 million. Misguided by the notion that a chapter 11 plan could force administrative claimants to accept less than payment in full, the Debtors offer a ***compulsory*** "Administrative Expense Claims Consent Program" that imposes an immediate 50% reduction on ordinary administrative claimants and establishes a paltry $12.5 million pro rata pot —an amount woefully insufficient to satisfy their claims. By contrast and to the detriment of the similarly situated ordinary administrative claimants, the Debtors propose to pay in full over $100 million in professional fees and expenses to lead counsel alone.

20. The second element of 11 U.S.C. § 1112(b)(4)(A) requires the Court to find an absence of reasonable likelihood of rehabilitation. "Courts usually require the debtor do more than manifest unsubstantiated hopes for a successful reorganization." *In re Canal Place Ltd. P'ship*, 921 F.2d 569, 577 (5th Cir. 1991). Courts have also found that a debtor lacks a reasonable likelihood of rehabilitation where its only source of income is speculative. *See In re Irasel Sand, LLC*, 569 B.R. 433, 442 (Bankr. S.D. Tex. 2017) (citing *Quarles v. U.S. Tr.*, 194 B.R. 94, 97 (W.D.

Va. 1996)); *In re Original IFPC Shareholders, Inc.*, 317 B.R. 738, 743–44 (Bankr. N.D. Ill. 2004). Moreover, rehabilitation has been defined as whether the debtor will be able to reestablish its business—"the standard under section 1112(b)(4)(A) is not the technical one of whether the debtor can confirm a plan, but, rather, whether the debtor's business prospects justify continuance of the reorganization effort." *In re Irasel Sand, LLC*, 569 B.R. 433, 442 (Bankr. S.D. Tex. 2017) (quoting 7 *Collier on Bankruptcy* ¶ 1112.04[6][a][ii]).

21. The Court should dismiss or convert these cases because the Debtors have no realistic prospect for reorganization. The Debtors have sold all of their hospitals and are pursuing a plan of liquidation—there are no jobs left to preserve, no patients left to serve, and the estates' remaining functions consist solely of pursuing litigation claims that could just as effectively be administrated by a trustee in a Chapter 7 case. Moreover, the proposed plan cannot be confirmed because it directly contravenes the Bankruptcy Code and general principles of fairness to creditors. The plain language of Section 1129(a)(9)(A) requires that "with respect to a claim of a kind specified in section 507(a)(2) or 507(a)(3) of this title, on the effective date of the plan, the holder of such claim will receive on account of such claim cash equal to the allowed amount of such claim." Yet, the Debtors do not propose to pay even their own optimistic estimate of $127 million in administrative expenses by the effective date. Instead, they attempt to circumvent this requirement through a coercive "Administrative Expense Claims Consent Program," which is inconsistent with the Bankruptcy Code's core protection for ordinary administrative claimants. *See* 11 U.S.C. § 507. Furthermore, the Plan improperly gerrymanders similarly situated creditors by requiring ordinary administrative claimants to immediately take a 50% reduction under the pretense of consent while professional fees are paid in full. *See* 11 U.S.C. § 1123(a)(4). Even if the Debtors prevailed in their admin claim objections, and in the best-case scenario of $127

million, they still have not set aside this amount to pay administrative claims. As drafted in the Plan, the estates have no reasonable likelihood of rehabilitation and the second element of Section 1112(b)(4)(A) is satisfied.

V. BASIS FOR EXPEDITED RELIEF

22. The Court scheduled the Solicitation Motion and Disclosure Statement hearing for May 29, 2025, at 10:30 a.m. *See* ECF No. 4777. As argued above, the Court should not allow the Debtors to begin an expensive solicitation process when the terms of the Plan are violative of the Bankruptcy Code. The U.S. Trustee's request for conversion of these cases should be resolved prior to any approval of the solicitation process. Additionally, employees of certain deferred compensation plans also requested emergency relief for conversion of these cases, which the U.S. Trustee believes that his conversion request should be heard at the same time. *See* ECF No. 4912. Accordingly, it is in the best interest of the estates and parties in interest to consider the U.S. Trustee's motion on an expedited basis.

WHEREFORE, the U.S. Trustee respectfully requests this Court enter an order, on an expedited basis, converting these cases to cases under Chapter 7 of the Bankruptcy Code, and for such other relief as this Court deems just.

Date: May 25, 2025

Respectfully Submitted,

KEVIN M. EPSTEIN
UNITED STATES TRUSTEE
REGION 7, SOUTHERN AND WESTERN
DISTRICTS OF TEXAS

By: */s/ Ha Nguyen*
Ha Nguyen, Trial Attorney
CA Bar #305411
Fed. ID No. 3623593
United States Department of Justice
Office of the United States Trustee
515 Rusk Street, Suite 3516
Houston, Texas 77002

E-mail: Ha.Nguyen@usdoj.gov
Cell: 202-590-7962

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was served by electronic means via ECF transmission to all Pacer System participants in these bankruptcy cases on May 25, 2025.

/s/ Ha Nguyen
Ha Nguyen, Trial Attorney

CERTIFICATE OF ACCURACY

I certify that, to the best of my knowledge and belief, the foregoing is true and correct.

/s/ Ha Nguyen
Ha Nguyen, Trial Attorney

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

IN RE:	§	
	§	**CASE NO. 24-90213**
STEWARD HEALTH CARE SYSTEM,	§	
LLC.,[1]	§	**CHAPTER 11**
	§	
DEBTORS.	§	

ORDER GRANTING UNITED STATES TRUSTEE'S EXPEDITED MOTION TO DISMISS OR CONVERT PURSUANT TO 11 U.S.C. § 1112(B)

CAME ON to be considered the United States Trustee's Expedited Motion to Dismiss or Convert Pursuant to 11 U.S.C. § 1112(b). Due notice and opportunity for hearing having been given to all parties by the Clerk, and it having been shown to the satisfaction of the Court that cause exists under 11 U.S.C. § 1112(b), it is hereby **ORDERED** that the Chapter 11 cases **Steward Health Care System LLC** are

_____**DISMISSED** _____ **Converted to Chapter 7 cases**

SIGNED this _____day of _____, 2025.

_____
CHRISTOPHER LOPEZ
UNITED STATES BANKRUPTCY JUDGE

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201

EXHIBIT E

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re:	§	**Chapter 11**
STEWARD HEALTH CARE SYSTEM LLC, *et al.*,	§	**Case No. 24-90213 (CML)**
	§	**(Jointly Administered)**
Debtors.[1]	§	

JOINDER AND RESERVATION OF RIGHTS OF TRACO INTERNATIONAL GROUP S. DE R.L. TO (I) EMERGENCY MOTION TO CONVERT THE DEBTORS' CASES TO CASES UNDER CHAPTER 7 OF THE BANKRUPTCY CODE FILED BY THE PARTICIPANTS IN THE DEFERRED COMPENSATION PLANS, AND (II) UNITED STATES TRUSTEE'S EXPEDITED MOTION TO DISMISS OR CONVERT PURSUANT TO 11 U.S.C. § 1112(B)

TRACO International Group S. De R.L. ("TRACO"), creditor and counterparty to various insurance policies with Steward Health Care System LLC and its debtor affiliates in these Chapter 11 cases (collectively, the "Debtors") including medical malpractice policies, by and through its undersigned counsel, files this joinder (this "Joinder") to the following motions (collectively, the "Motions to Convert"): (1) *Emergency Motion to Convert the Debtors' Cases to Cases under Chapter 7 of the Bankruptcy Code* [Docket No. 4912], filed by Dr. Manisha Purohit, Dr. Diane Paggioli, Dr. James Thomas, Dr. Thomas Ross, Dr. Michael Regan, Dr. Peter Lydon, Dr. Sridhar Ganda and Dr. A. Ana Beesen (collectively, the "Participants"), participants in and beneficiaries of certain deferred compensation plans sponsored by the Debtors; and (2) *United States Trustee's Expedited Motion to Dismiss or Convert Pursuant to 11 U.S.C. § 1112(B)* [Docket No. 4964], filed by Kevin M. Epstein, the United States Trustee for the Southern District of Texas (the "U.S. Trustee"). In support of this Joinder, TRACO respectfully represents as follows:

[1] A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' claims and noticing agent at https://restructuring.ra.kroll.com/Steward. The Debtors' service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

BACKGROUND

1. TRACO is a non-debtor captive insurer of the Debtors that provided the Debtors with insurance coverage, including medical malpractice insurance, both prepetition and post-petition.

2. On December 2, 2024, TRACO filed a motion [Docket No. 3341] (the Premiums Motion") seeking the payment of unpaid premiums due under certain insurance policies. TRACO is owed at least $28 million in post-petition premiums. Additionally, on December 6, 2024, TRACO commenced an adversary proceeding [Adversary Proceeding No. 24-03261], seeking, among other things, the turnover of approximately $170 million of TRACO's property in the possession of and improperly retained by the Debtors. These amounts comprise distributions from and proceeds of a sale of a limited partnership in which TRACO held ownership units.

3. The Debtors have acknowledged that the amount of the intercompany balance owed to TRACO is $259 million.

4. Based upon TRACO's calculations, however, it is TRACO's position that the total amount due and owing from the Debtors is $360 million.

5. On April 28, 2025, the Debtors filed the Motion [Docket No. 4745] (the "Disclosure Statement Motion") seeking, *inter alia*, conditional approval of the Disclosure Statement [Docket No. 4744] (the "Disclosure Statement") for Joint Chapter 11 Plan of Liquidation of Steward Health care System LL and its Affiliated Debtors [Docket No. 4743] (the "Plan").

6. Also on April 28, 2025, the Debtors filed the *Motion of Debtors for Entry of an Order (I) Approving Settlement with FILO Secured Parties; (II) Authorizing and Directing Transfer of Assets in Connection Therewith; (III) Authorizing Amendment to FILO DIP Credit Agreement and Continued Use of Cash Collateral; (IV) Granting Adequate Protection; (V) Approving Assumption and Assignment Procedures and Form and Manner of Notice of*

Assumption and Assignment, and (VI) Granting Related Relief [Docket No. 4746] (the "FILO Settlement Motion") seeking final approval of a comprehensive settlement (the "Settlement Agreement") by and between the Debtors, the FILO Secured Parties, and the committee of unsecured creditors (the "Committee"), with such final approval to be obtained prior to confirmation of the Plan.

7. On May 19, 2025, TRACO filed objections to the Disclosure Statement Motion and the FILO Settlement Motion [Docket numbers 4923 and 4919, respectively] (the "Objections").

JOINDER AND RESERVATION OF RIGHTS

8. TRACO hereby joins in and fully incorporates by reference the arguments set forth in the Motions to Convert for the reasons asserted therein. TRACO also fully incorporates herein its arguments asserted in the Objections.

9. Specifically, the Disclosure Statement Motion and the FILO Settlement Motion should be denied and the Debtors' cases should be converted to chapter 7 because, *inter alia*, (i) the Debtors are administratively insolvent and have no means of paying administrative claims; (ii) the Settlement Agreement constitutes an improper sub rosa plan that bypasses the safeguards of the chapter 11 confirmation process; (iii) the Settlement Agreement contemplates the transfer of substantially all of the Debtors' remaining assets to a liquidation trust, even if the Plan is not confirmed, depriving creditors of their statutory right to vote on the Plan and the protections provided by section 1129 of the Bankruptcy Code; (iv) the Settlement Agreement establishes a distribution waterfall that prioritizes repayment of the FILO Secured Parties prior to any value flowing to the estates or unsecured creditors, in contravention of the "fair and equitable" and "best interests of creditors" test under section 1129 of the Bankruptcy Code; (v) the Settlement Agreement provides for overly broad releases to not only the FILO Secured Parties but also various individuals, including members of the Transformation Committee, for all actions both

pre and post-bankruptcy, including the Transformation Committee's handling of asset sales and ongoing operations; (vi) the Settlement Agreement provides that the releases may become effective and binding on all creditors and parties in interest prior to plan confirmation, thereby depriving creditors to vote directly on the releases as part of the Plan; (vii) the Plan is unconfirmable because there is a continuing loss and diminution of the Debtors' estates because the Debtors continue to accrue administrative expenses that they have no ability to pay; and (viii) there is no reasonable likelihood of rehabilitation.

10. Accordingly, TRACO joins in the Motions to Convert.

11. TRACO reserves all of its rights, claims, defenses, and remedies, including, without limitation, the right to amend, modify, or supplement this Joinder, and assert any and all additional arguments regarding the Plan, the Disclosure Statement, the Disclosure Statement Motion and the FILO Settlement Motion.

CONCLUSION

WHEREFORE, for the reasons set forth in this Joinder and the Objections, TRACO respectfully requests that the Court grant the relief requested in the Motions to Convert.

Respectfully submitted,

Dated: May 29, 2025

By: /s/ Timothy Walsh

Timothy Walsh
STEPTOE LLP
1114 Avenue of the Americas
New York, NY 10036
Telephone: (212) 957-3085
Email: twwalsh@steptoe.com

Counsel for TRACO International Group S. De R.L.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on May 29, 2025, a copy of the foregoing document was duly served to all registered parties through the CM/ECF system for the United States Bankruptcy Court for the Southern District of Texas.

/s/ Timothy Walsh
Timothy Walsh

EXHIBIT L

Massachusetts Appeals Court Docket Sheet

APPEALS COURT
Full Court Panel Case
Case Docket

MELISSA CAPPIELLO vs. STEVEN BBUYE & another
2026-P-0138

CASE HEADER

Case Status	Stayed till certain date
Status Date	05/05/2026
Nature	Malpractice: medical
Entry Date	02/05/2026
Appellant	Defendant
Case Type	Civil
Brief Status	Awaiting blue brief
Brief Due	03/17/2026
Arg/Submitted	
Decision Date	
Panel	
Citation	
Lower Court	Plymouth Superior (Brockton)
TC Number	1983CV00842
Lower Ct Judge	Daniel J. O'Shea, J.
TC Entry Date	06/05/2019
SJ Number	
FAR Number	
SJC Number	

INVOLVED PARTY	ATTORNEY APPEARANCE
Melissa Cappiello Plaintiff/Appellee Awaiting red brief Due 07/06/2026	Andrew C. Meyer, Jr., Esquire Robert M. Higgins, Esquire Andrew H. Miller, Esquire Brooke Sheldon, Esquire
Steven Bbuye Defendant/Appellant Awaiting blue brief Due 03/17/2026	Sean E. Capplis, Esquire Allyson Louise Gay, Esquire
Vera McCullen Defendant/Appellant Stay granted	Joshua W. Gardner, Esquire Sean E. Capplis, Esquire - Withdrawn Allyson Louise Gay, Esquire - Withdrawn

DOCKET ENTRIES

Entry Date	Paper	Entry Text
02/05/2026	#1	Lower Court Assembly of the Record Package
02/05/2026		Notice of entry sent.
02/05/2026	#2	Civil Appeal Entry Form filed for Vera McCullen, P.A. by Joshua W. Gardner.
02/12/2026	#3	Civil Appeal Entry Form filed for Steven Bbuye by Attorney Allyson Gay.
02/12/2026	#4	MOTION to withdraw as counsel filed for Vera McCullen by Attorney Allyson Gay.
02/12/2026	#5	Motion for leave to file brief separately filed for Steven Bbuye by Attorney Allyson Gay.
02/18/2026	#6	Docketing Statement filed for Vera McCullen by Attorney Ashleigh Bell.
02/18/2026	#7	RESPONSE to Paper #4, filed for Vera McCullen by Attorney Ashleigh Bell.
02/20/2026	#8	Docketing Statement filed for Steven Bbuye by Attorney Allyson Gay.
02/20/2026	#9	MOTION of Appellant to stay appellate proceedings filed for Steven Bbuye by Attorney Allyson Gay.
02/25/2026	#10	Notice of Non-Opposition to paper #4 filed for Vera McCullen by Attorney Ashleigh Bell.
02/27/2026		RE##4, 7, & 10: After review, the motion to withdraw as counsel for the defendant, Vera McCullen, P.A., in this appeal is allowed. Attorney Sean E. Capplis and Attorney Allyson L. Gay, and the law firm of Capplis, Connors, Carroll & Ennis, are withdrawn as counsel for the defendant, Vera McCullen, P.A., in this appeal only. *Notice
02/27/2026		RE#5: Allowed. *Notice.
02/27/2026		RE#9: Any response is due on or before 3/5/26. *Notice.

02/27/2026	#11	Notice of Non-Opposition to paper #9 filed for Vera McCullen by Attorney Ashleigh Bell.
03/02/2026		RE#9: Allowed. Appellate proceedings are stayed to 05/04/2026. Status report due then concerning action on the motion to determine the applicability of the automatic stay filed by appellant Steven Bbuye in the Bankruptcy Court. *Notice.
05/04/2026	#12	Status Report filed for Steven Bbuye by Attorney Allyson Gay.
05/05/2026		RE12: Appellate proceedings remain stayed to 06/04/2026. Status report due then concerning action on the motion to determine the applicability of the automatic stay filed by appellant Steven Bbuye in the Bankruptcy Court. *Notice.

As of 05/05/2026 12:15pm

EXHIBIT L

Raju Order & Motion to Compel

COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, SS.

SUPERIOR COURT
DEPARTMENT OF
THE TRIAL COURT

ALLISON KELLY AND RYAN KELLY, INDIVIDUALLY AND AS PARENTS AND NEXT FRIENDS OF ARIYA KELLY, A MINOR,

Plaintiffs,

v.

KIRAN RAJU, D.O.,

Defendant.

2483CV00859

PLAINTIFFS' MOTION TO COMPEL DISCLOSURE OF THE DEFENDANT'S INSURANCE COVERAGE

The plaintiffs hereby move to compel the defendant, Kiran Raju, D.O., and his insurer, TRACO International Group S. DE R.L. ("TRACO"), to provide documents and information sufficient to show that Dr. Raju's malpractice insurance coverage exists, and that his disclosed insurance policy from TRACO is actually backed by money to satisfy any judgment issued in this case. As reasons for this Motion, the plaintiffs state that they have more than reasonable suspicion that in this catastrophic birth injury case, Dr. Raju is being defended by an insurer whose policies of insurance are not real. If the Court does not Order Dr. Raju and TRACO to provide proof of TRACO's ability to pay any judgment, then the parties will spend tens of thousands of dollars on the litigation of this claim, and the Court will spend its considerable and stretched resources, all because of an insurance company that is disclosing policies it knows not to be backed by any actual funds.

In support of this Motion, please see the plaintiffs' accompanying Memorandum.

PLAINTIFFS,

By Their Attorneys,

SUGARMAN AND SUGARMAN, P.C.

Benjamin R. Zimmermann, Esq. - BBO# 643920
bzimmermann@sugarman.com
David P. McCormack, Esq. – BBO# 659006
dmccormack@sugarman.com
31 St. James Avenue, 10th Floor
Boston, MA 02116
(617) 542-1000

DATED: October 8, 2025

Certificate of Service

I hereby certify that a true copy of the above document was served by e-mail only, on October 8, 2025, upon the attorney of record for each party:

Daniel J. Buoniconti
Bridget M. Ruboy
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David P. McCormack

12/26/25

18

COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, SS.

SUPERIOR COURT
DEPARTMENT OF
THE TRIAL COURT

FILED
COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT DEPT. OF THE TRIAL COURT
PLYMOUTH COUNTY

OCT 28 2025

Clerk of Court

ALLISON KELLY AND RYAN KELLY, INDIVIDUALLY AND AS PARENTS AND NEXT FRIENDS OF ARIYA KELLY, A MINOR,

Plaintiffs,

v.

KIRAN RAJU, D.O.,

Defendant.

2483CV00859

PLAINTIFFS' MOTION TO COMPEL DISCLOSURE OF THE DEFENDANT'S INSURANCE COVERAGE

The plaintiffs hereby move to compel the defendant, Kiran Raju, D.O., and his insurer, TRACO International Group S. DE R.L. ("TRACO"), to provide documents and information sufficient to show that Dr. Raju's malpractice insurance coverage exists, and that his disclosed insurance policy from TRACO is actually backed by money to satisfy any judgment issued in this case. As reasons for this Motion, the plaintiffs state that they have more than reasonable suspicion that in this catastrophic birth injury case, Dr. Raju is being defended by an insurer whose policies of insurance are not real. If the Court does not Order Dr. Raju and TRACO to provide proof of TRACO's ability to pay any judgment, then the parties will spend tens of thousands of dollars on the litigation of this claim, and the Court will spend its considerable and stretched resources, all because of an insurance company that is disclosing policies it knows not to be backed by any actual funds.

In support of this Motion, please see the plaintiffs' accompanying Memorandum.

11/24/2025 - Denied after hearing. While Defendant must disclose/produce information and material in his possession, custody and control, the insurer is not the insured and does not possess or control the information in dispute. Leighton, J.

EXHIBIT M

Dressel Order & Motion to Sever

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

SUPERIOR COURT
CIVIL ACTION
NO. 2481CV00123

GEORGE RICHARDSON AND
NANCY RICHARDSON,
Plaintiffs,
V.

BRIAN DRESSEL, M.D.,
JEFFREY POTTER, M.D.,
SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC. D/B/A PEPPERELL FAMILY PRACTICE, AND
NASHOBA VALLEY MEDICAL CENTER, A STEWARD FAMILY HOSPITAL, INC. D/B/A NASHOBA VALLEY MEDICAL CENTER,
Defendants.

PLAINTIFFS' MOTION TO SEVER CLAIMS AGAINST NASHOBA VALLEY MEDICAL CENTER, A STEWARD FAMILY HOSPITAL, INC. D/B/A NASHOBA VALLEY MEDICAL CENTER DUE TO BANKRUPTCY STAY

NOW COME the Plaintiffs, George Richardson and Nancy Richardson, and respectfully request this Court sever the claims against Brian Dressel, M.D., Jeffrey Potter, M.D., and Southern New Hampshire Medical Center, Inc. D/B/A Pepperell Family Practice, (hereinafter the "Non-bankrupt Defendants"), from the claims against Nashoba Valley Medical Center, A Steward Family Hospital, Inc. D/B/A Nashoba Valley Medical Center (hereinafter the "Steward Defendant"), so as to permit the plaintiffs to proceed against Brian Dressel, M.D., Jeffrey Potter, M.D., and Southern New Hampshire Medical Center, Inc. D/B/A Pepperell Family Practice. Although the claims against the Steward Defendant are properly stayed pursuant to 11 U.S.C. § 362(a) while the Steward Bankruptcy proceeds, see Docket No. 11, none of the Non-bankrupt Defendants, nor their insurance carriers, are

debtors in the bankruptcy. Accordingly, this simple procedural step will allow the parties and this Court to respect the automatic stay to which Steward Defendant is entitled while Mr. Richardson, who is actively dying of his bladder cancer, may proceed in an efficient manner with his claims against the Non-bankrupt Defendants, who are not entitled to a stay of litigation against them. Notably, this exact issue was recently litigated in another medical malpractice case and plaintiff's motion was allowed by the Honorable Elizabeth Dunigan. See **Exhibit A**, Clerk's Notice of Allowance of Pls.'s Mot. to Sever Claims Against Steward Holy Family Hosp., Inc. and Steward Health Care Sys., LLC Due to Bankruptcy Stay, Uzdavinis et al. v. Niakosari, M.D., et al., No. 2377CV00414 (Mass. Super. Ct. May 6, 2025).

BACKGROUND

In this medical malpractice case, the plaintiffs have sued various defendants, including the Steward Defendant, for damages related to the Non-bankrupt Defendants' care and treatment of George Richardson. The plaintiffs allege that the Non-bankrupt Defendants provided substandard medical care and treatment that resulted in the significant delay and diagnosis of Mr. Richardson's prostate cancer. Specifically, the plaintiffs allege that Dr. Dressel, as Mr. Richardson's primary care provider, failed to follow up on concerning findings seen on CT scan as noted by co-defendant, Dr. Potter. The plaintiffs' allegations as to Dr. Potter involve his failure to contact Dr. Dressel by phone to inform him of the concerning findings. Importantly, these findings are noted in the radiology report, which was sent to Dr. Dressel directly. Presently, Mr. Richardson's Stage III bladder cancer has returned and he is undergoing treatment once again.

On May 6, 2024, while this case was ongoing, Steward Health Care System, LLC and most of its affiliated subsidiaries filed for Bankruptcy in the United States Bankruptcy Court for the Southern District of Texas. The Steward Defendant in this case filed a Notice of Suggestion of Bankruptcy on May 21, 2024, Docket No. 11. The Non-bankrupt Defendants are not debtors in the Steward Bankruptcy, nor are their insurance carriers, and, therefore, the Non-bankrupt Defendants are not entitled to have the proceedings stayed against them.

ARGUMENT AND AUTHORITIES

The plaintiffs ask this Court to sever the claims against the Steward Defendant from the rest of its lawsuit against the Non-bankrupt Defendants, leaving proceedings stayed against the Steward Defendant (pursuant to federal law) but allowing litigation to proceed against the Non-bankrupt Defendants. Severance of the bankrupt defendant will serve to (1) avoid the severe prejudice to the plaintiffs caused by an indefinite stay of all their claims, including those brought against non-bankrupt defendants that are not entitled to a stay of litigation against them; and (2) expediently and economically move towards resolution of claims against non-bankrupt defendants that are pending in this Court and occupying space in a busy Court docket. The claims against the Steward Defendant being vicarious in nature, advancement of the claims against the Non-bankrupt Defendants alone is warranted.

A court in Massachusetts may separate claims and parties "in furtherance of convenience or to avoid prejudice, or when [separation] will be conducive to expedition and economy". Mass R. Civ. P. 42(b). Rule 42(b) is "devoted to the convenience of adjudication, the avoidance of prejudice and the interests of expedition and economy as dictated by the characteristics and elements of proof of the claims themselves." Roddy & McNulty Ins. Agency, Inc. v. A.A. Proctor & Co., 16 Mass. App. Ct. 525, 528 (1983). Rule 42(b) grants

trial judges "discretion to separate parties, claims, and issues in order to avoid prejudice or in the interest of expedition and economy." Cambridge Trust Co. v. Commercial Union Ins. Co., 32 Mass. App. Ct. 561, 565 (1992), citing Mass. R. Civ. P. 42(b), Opinion of Justices, 365 Mass. 805 (1974); Dobos v. Driscoll, 404 Mass. 634, 644-645 (1989); Roddy & McNulty Ins. Agency, Inc. v. A.A. Proctor & Co., 16 Mass. App. Ct. 525, 528-529 (1983).

An automatic stay does not apply to a debtor's codefendants in pending litigation. Allegheny Int'l Credit Corp. v. Bio-Energy of Lincoln, Inc., 21 Mass. App. Ct. 155, 158 (1985) ("The automatic stay provisions of the Bankruptcy Code apply only to a 'proceeding against the [petitioning] debtor,' . . . and not against others. Thus, the stay provisions have been held not to apply to proceedings against a codefendant of the debtor.") (internal citations omitted). The rule on this issue is the same under precedent from both the First Circuit Court of Appeals and the Fifth Circuit Court of Appeals (which has Appellate Jurisdiction over Texas, where the bankruptcy was filed and is proceeding). Compare Austin v. Unarco Industries, Inc., 705 F.2d 1, 4 (1st Cir. 1983) ("[T]he Bankruptcy Court has made clear its position that the automatic stay of all proceedings against bankrupt debtors provided by sec. 362(a) of the Bankruptcy Code, 11 U.S.C. sec. 362(a), applies only to the debtor and not to the debtor's solvent co-defendants . . . [and] we express our judgment that the Bankruptcy Court was correct . . . ."); with Marcus, Stowell & Beye Gov't Sec., Inc. v. Jefferson Inv. Corp., 797 F.2d 227, 230 n.4 (5th Cir. 1986) ("The well established rule is that an automatic stay of judicial proceedings against one defendant does not apply to proceedings against co-defendants."). Accordingly, it is common for a court to sever stayed claims against bankrupt defendants from other claims against solvent defendants, permitting those claims unrelated to a bankrupt defendant to proceed unhindered. See, e.g, Beverly v.

Bass River Golf Mgt., Inc., 92 Mass. App. Ct. 595, 599 (2018); Nitro Dynamics, Inc. v. Petruzzi Bros., 24 Mass. L. Rep. 493 (2008).

The plaintiffs request that this Court sever the stayed proceedings against the Steward Defendant from the active proceedings against the Non-bankrupt Defendants, so that the plaintiffs may proceed toward trial against the Non-bankrupt Defendants. Such a procedure is available under this Court's rules and satisfies the requirements of federal bankruptcy law, as it leaves the claims against the Steward Defendant separately severed, stayed, and otherwise wholly untouched. The law does not, however, entitle a non-bankrupt defendant to an indefinite stay of litigation while the Texas Bankruptcy Court works through an interminable[1] process in which the Non-bankrupt Defendants are not involved.

CONCLUSION

For the aforementioned reasons, the plaintiffs, George Richardson and Nancy Richardson, respectfully request this Honorable Court sever the stayed claims against the Steward Defendant from the active claims against the Non-bankrupt Defendants, pursuant to Massachusetts Rule of Civil Procedure 42(b).

[1] The Steward bankruptcy docket contains thousands of entries. There is no way to estimate when the Steward bankruptcy may conclude, and an indefinite delay of the plaintiff's claims against the Non-bankrupt Defendants is neither just nor required.

Respectfully submitted,
THE PLAINTIFFS,
By their attorneys,

/s/ Adam R. Satin

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A

CLERK'S NOTICE

DOCKET NUMBER

2377CV00414

Trial Court of Massachusetts

The Superior Court

CASE NAME:

Susanne Uzdavinis, Personal Representative Of The Estate Of Thomas Uzdavinis et al vs. Niakosari, M.D., Ali et al

Thomas H. Driscoll, Jr., Clerk of Courts
Essex County

TO:

Andrew H Miller, Esq.
Lubin and Meyer, P.C.
28 State St
40th Floor
Boston, MA 02109

COURT NAME & ADDRESS

Essex County Superior Court - Lawrence
43 Appleton Way
Lawrence, MA 01841

You are hereby notified that on 05/09/2025 the following entry was made on the above referenced docket:

Endorsement on Motion to sever and stay an action Plaintiff's Motion to Sever Claims Against Steward Holy Family Hospital, Inc. d/b/a Holy Family Hospital, and Steward Health Care System, LLC Due to Bankruptcy Stay (#42.0): ALLOWED
Motion ALLOWED. Claims against Steward Holy Family Hospital and Steward Health Care System, LLC have been stayed as a result of Bankruptcy filing. The case should proceed against the four (4) non-Bankruptcy defendants in the interests of justice, judicial expedition and economy. Severance is appropriate and justified. Dated 5/6/2025.

DATE ISSUED	ASSOCIATE JUSTICE/ ASSISTANT CLERK	SESSION PHONE#
05/09/2025	**Hon. Elizabeth Dunigan**	**(978)242-1900**

CLERK'S NOTICE

DOCKET NUMBER

2481CV00123

Trial Court of Massachusetts

The Superior Court

CASE NAME:

Richardson, George et al vs. Dressel, MD, Brian et al

Michael A. Sullivan, Clerk of Court
Middlesex County

TO:

Sean Eric Capplis, Esq.
Capplis, Connors, Carroll and Ennis P.C.
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COURT NAME & ADDRESS

Middlesex Superior - Lowell
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You are hereby notified that on 03/12/2026 the following entry was made on the above referenced docket:

Endorsement on Motion to Sever Claims against Nashoba Valley Medical Center, a Steward Family Hospital, Inc. d/b/a Nashoba Valley Medical Center due to Bankruptcy Stay (#17.0): DENIED after hearing. However discovery against the Defendant Nashoba shall be allowed and any disputes with respect to said discovery shall be litigated in the Superior Court to the extent that it is allowed by law.

Judge: Barrett, Hon. C. William

DATE ISSUED	ASSOCIATE JUSTICE/ ASSISTANT CLERK	SESSION PHONE#
03/12/2026	**Hon. C. William Barrett**	**(978)453-4181**