Docket #6953 Date Filed: 5/29/2026

MUSICK, PEELER & GARRETT LLP

333 South Hope Street, Suite 2900
Los Angeles, California 90071-3048
Telephone (213) 629-7600
Facsimile (213) 624-1376

Isis D. Miranda (State Bar No. 313855)
i.miranda@musickpeeler.com

Attorneys for Plaintiff
VHS LIQUIDATING TRUST, liquidating trust for Verity Health System of California, Inc. (formerly known as Daughters of Charity Health System)

UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA – LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al*. Debtors and Debtors In Possession.	Lead Case No. 2:18-bk-20151-BB[1] Chapter 11 Cases Adv. No.: _____ **ADVERSARY COMPLAINT FOR:** **(1) DECLARATORY JUDGMENT REGARDING DUTY TO DEFEND** **(2) DECLARATORY JUDGMENT REGARDING DUTY TO INDEMNIFY** **(3) BREACH OF CONTRACT** **(4) BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING**
VHS LIQUIDATING TRUST, liquidating trust for Verity Health System of California, Inc. (formerly known as Daughters of Charity Health System), Plaintiff, v. FEDERAL INSURANCE COMPANY, a New Jersey corporation, Defendant.	

[1] Jointly administered with Case Nos. 2:18-bk-20162-ER; 2:18-bk-20163-BB; 2:18-bk-20164-BB; 2:18-bk-20165-BB; 2:18-bk-20167-BB; 2:18-bk-20168-BB; 2:18-bk-20169-BB; 2:18-bk-20171-BB; 2:18-bk-20172-BB; 2:18-bk-20173-BB; 2:18-bk-20175-BB; 2:18-bk-20176-BB; 2:18-bk-20178-BB; 2:18-bk-20179-BB; 2:18-bk-20180-BB; and 2:18-bk-20181-BB.

1820151260604000000000006

VHS LIQUIDATING TRUST, liquidating trust for Verity Health System of California, Inc. (formerly known as Daughters of Charity Health System) (referred to herein as "Verity"), one of the debtors in the above-captioned Chapter 11 case, brings this adversary Complaint on behalf of its former directors and members of its Benefits Administration Committee to whom Verity may owe a duty to indemnify. In support of its Complaint against Federal Insurance Company ("Federal"), Verity alleges, upon information and belief, as follows:

INTRODUCTION

1. This is an insurance coverage action in which Verity seeks judicial declarations that Federal owes a duty to defend and indemnify the defendants in an action captioned *Rachel Oden v. Richard G. Adcock, et al.*, Adversary Case No. 2:26-ap-01044-BB, which was referred to this Court by the United States District Court, Central District of California, bearing Case No. 2:24-cv-07430-CV-RAO (the "*Oden* Action").[2]

2. Federal wrongfully denied that it has a duty to defend or indemnify the defendants in the *Oden* Action on the basis that, *inter alia*, the *Oden* Action relates back to allegations made in a prior action captioned *Lynn Morris, et al. v. Daughters of Charity Health System, et al.*, United States District Court, Northern District of California, Case No. 14-cv-4681 (the "*Morris* Action").

JURISDICTION AND VENUE

3. This Court has jurisdiction over this adversary proceeding pursuant to Section 14.1(e) of the Modified Second Amended Joint Chapter 11 Plan of Liquidation (Dated July 2, 2020) of the Debtors, the Prepetition Secured Creditors, and the Committee (the "Bankruptcy Plan"), which provides as follows: "[T]he Bankruptcy Court shall retain jurisdiction over all matters arising in, arising under,

[2] A pending Motion to Dismiss the *Oden* Action is set to be heard on June 9, 2026, before this Court. *See* Adversary Case No. 2:26-ap-01044-BB, Doc. 5.

or related to the Chapter 11 Cases. Without limiting the foregoing, the Bankruptcy Court shall retain jurisdiction to: . . . hear and determine matters relating to claims with respect to the Debtors' director and officer insurance." A copy of the Bankruptcy Plan (Doc. No. 5466 in the Lead Case, No. 2:18-bk-20151-BB) is attached as **Exhibit 1.**

4. This Court also has subject matter jurisdiction over this adversary proceeding pursuant to 28 U.S.C. §§ 1334(b) and 157(a). This is a core proceeding under 28 U.S.C. § 157(b)(2)(A) (matters concerning the administration of the estate) and (O) (other proceedings affecting the liquidation of the assets of the estate or the adjustment of the debtor-creditor relationship). The insurance policy at issue is a significant asset of Verity's bankruptcy estate, and a determination of coverage rights directly affects the administration of the estate and the potential distribution to creditors.

5. This Court has authority to enter a final judgment as this matter is a core proceeding. In the alternative, if this matter is determined to be a non-core, related-to proceeding, Verity consents to this Court hearing the matter and entering final orders and judgments pursuant to 28 U.S.C. § 157(c)(2).

6. This action for declaratory relief is authorized by the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202 and Federal Rule of Bankruptcy Procedure 7001(9).

7. Venue is proper in this Court pursuant to 28 U.S.C. § 1409(a) because this adversary proceeding arises out of and is related to Verity's Chapter 11 case, which is pending in this Court.

PARTIES

8. VHS Liquidating Trust is the bankruptcy liquidator for Verity Health System of California, Inc., which was a nonprofit healthcare services organization existing under the laws of the State of California and with its principal place of business in California.

9. Federal is a corporation organized and existing under the laws of the State of New Jersey and has its principal place of business in Indianapolis, Indiana.

THE *MORRIS* ACTION

10. The Complaint in the *Morris* Action was filed on October 21, 2014, by Plaintiffs Lynn Morris, Caroline Plaza, Veronica Tench, Jacqueline Murray, Maidaflor Maybir, Jocelyn Manacmul, Donna Guitierrez, Eleanore De Dios, and Elenita Santos-Funai, on behalf of themselves and all others similarly situated, (collectively, the "Morris Plaintiffs") against Defendants Robert Issai, Stephanie Battles, Mike Stuart, Daughters of Charity Health System, Daughters of Charity Ministry Services Corporation, Daughters of Charity of St. Vincent de Paul, and DOES 1 through 20 (collectively, the "Morris Defendants"). The Morris Complaint is attached as **Exhibit 2.**

11. The Morris Complaint alleges:

- Plaintiffs were employees of hospitals owned by the Daughters of Charity Health System who were entitled to defined benefit pensions under the Daughter of Charity Health System Retirement Plan (the "Plan") and who were harmed by Defendants' mismanagement of the Plan. (Morris Complaint, ¶¶ 1-2.); and
- Defendants improperly classified the Plan as a "Church Plan" and in so doing violated the Employee Retirement Income Security Act ("ERISA"). (*Id*., ¶¶ 53-91.)

12. Based on these allegations, the Complaint asserts the following causes of action pursuant to the ERISA statute: (1) Declaratory and Equitable Relief (declaring that the Plan is not a Church Plan and directing the defendants to bring the Plan into compliance with ERISA); (2) Violation of Reporting and Disclosure Provisions (including failure to provide summary plan descriptions, annual reports, funding notices, pension benefit statements, etc.); (3) Failure to Provide Minimum Funding; (4) Failure to Establish the Plan Pursuant to a Written Instrument; (5)

Breach of Fiduciary Duty (failure to comply with ERISA requirements); and (6) Prohibited Transactions (use of money owed to the plan for general business purposes). (*Id.*, ¶¶ 107-167.)

THE *ODEN* ACTION

13. The original Complaint in the *Oden* Action was filed on August 30, 2024, by Plaintiff Rachel Oden, on behalf of herself and all others similarly situated, (collectively, the "Oden Plaintiffs") against Defendants Verity Health System Benefits Administration Committee, Chris Carson, Peter Chadwick, and Steven C. Sharrer.

14. On January 31, 2025, a First Amended Complaint ("FAC") was filed on January 31, 2025, identifying the members of the Benefits Administration Committee and adding additional defendants. The FAC contains the following two groups of defendants: (1) the Verity Benefits Administration Committee Defendants, which include Richard G. Adcock, B. Joseph Badalian, Chris Carson, Peter Chadwick, Anita Chou, Ty Conner, Stephen Forney, Michael Katz, and David Sachs; and (2) Verity Director Defendants, which include: Ernest H. Agatstein, James Barber, Terry Belmont, Mitchell Creem, Jeffrey Flocken, Jack Krouskup, S. Christina Maggi, Charles Patton, James Pieri, Andrew Pines, and Christobel E. Selecky (collectively, the "Oden Defendants"). The Oden FAC is attached as **Exhibit 3.**

15. The Oden FAC alleges:

- Plaintiff Oden was the daughter of the late Loraine Oden, a former employee of St. Francis Medical Center and a participant in the Plan who was harmed by Defendants' failure to hold the fiduciaries who had mismanaged the Plan accountable for their actions. (Oden FAC, ¶¶ 4, 6, 8, etc.);
- The Plan was underfunded "since at least 2002" and mismanaged "every year since approximately 2010." (*Id.*, ¶¶ 58-59)

- The Plan was converted from a "Church Plan" to a secular plan governed by ERISA "in July of 2015," and "the Plan was amended and restated *at that time* so as to make it expressly subject to the requirements of ERISA[.]" (*Id*., ¶¶ 77-79) (emphasis added).); and
- Defendants breached their fiduciary duties when they "took no action against the persons who had improperly operated the Plan as a church plan [and] left the Plan severely underfunded," including failing to file suit before the statute of limitations expired and failing to otherwise hold the Plan operators accountable for their actions. (*Id*., ¶¶ 6, 8, etc.)

16. Based on these allegations, the FAC asserts the following causes of action pursuant to the ERISA statute: (1) Breach of Fiduciary Duty (failure to file claims against former Plan fiduciaries); (2) Breach of the Duty to Monitor (failure to monitor the Plan trustees' conduct); and (3) Co-Fiduciary Liability (failure to file suit against former Plan fiduciaries). (*Id*., ¶¶ 114-141.)

THE FEDERAL POLICIES

17. Federal issued two policies, including: (1) Healthcare Portfolio policy no. 8209-2943 to Daughters of Charity of St. Vincent de Paul Province of the West with a policy period of July 1, 2014, to July 1, 2015, which provides Fiduciary Liability coverage with a $10 million limit per claim and Voluntary Settlement Program coverage ("DOCPW Policy"); and (2) Healthcare Portfolio policy no. 8224-0373 to Daughters of Charity Health System with a policy period of July 1, 2014 to July 1, 2015, which provides both Fiduciary Liability coverage with a $10 million limit of liability per claim and Crime coverage ("DOCHS Policy") (collectively the "Federal Policies").[3] The DOCHS Policy is attached as **Exhibit 4.**

[3] Despite repeated requests, Federal has not provided Verity with copies of the Federal Policies.

FEDERAL'S COVERAGE DENIAL

18. Federal denied any duty to defend or indemnify the Oden Defendants, contending, *inter alia*, that all of the wrongful acts were alleged to have taken place after the Federal Policies expired on July 1, 2015, thus ignoring the allegations pertaining to wrongful acts in, around, and before July 2015. Federal's January 10, 2025, coverage denial letter is attached as **Exhibit 5.**

19. Federal further denied coverage on the basis that the Oden Defendants did not qualify as insureds under Endorsement 7, amending Section 15(b) [Acquisition By Another Organization], of the Federal Policies because, *inter alia*, Integrity Healthcare, LLC ("Integrity") "acquire[d] the right to control or direct the managerial decisions" of Verity. Federal's assertion, however, ignores the fact that the Verity board maintained the ultimate authority over Integrity pursuant to the Health System Management Agreement ("Management Agreement") between them. (Management Agreement, ¶¶ 1.4, 1.6, etc.). The Management Agreement is attached as **Exhibit 6.**

20. Federal also reserved its right to deny coverage on the basis that the claims in the *Oden* Action relate back to the allegations in the *Morris* Action, thus ignoring: (1) the fact that the two actions were brought about a decade apart and involve distinct sets of defendants; and (2) the existence of new and distinct allegations in the *Oden* Action regarding the failure to prosecute the persons responsible for the alleged wrongdoing described in the *Morris* Action.

FIRST CLAIM FOR RELIEF

Declaratory Relief – Duty to Defend the *Oden* Action

21. Verity re-alleges and incorporates herein by reference each and every allegation and statement set forth in the preceding Paragraphs 1 through 20, as though each was fully set forth herein.

22. Federal contends that the Federal Policies do not afford coverage for the defense of the Oden Defendants in the *Oden* Action. Verity disputes Federal's assertion.

23. An actual controversy exists between Verity and Federal, regarding the respective rights and obligations of the Oden Defendants under the Federal Policies in connection with the *Oden* Action. Verity requests a judicial declaration that Federal has a duty to defend the Oden Defendants and any other person or entity qualifying as an insured under the Federal Policies in the *Oden* Action. Such a judicial declaration is necessary and proper at this time so that the parties will be bound by the same interpretation of the Federal Policies and adjudication of their rights and obligations thereunder.

SECOND CLAIM FOR RELIEF

Declaratory Relief – Duty to Indemnify the *Oden* Action

24. Verity re-alleges and incorporates herein by reference each and every allegation and statement set forth in the preceding Paragraphs 1 through 23, as though each was fully set forth herein.

25. Federal contends that the Federal Policies do not afford coverage for the indemnity of the Oden Defendants in the *Oden* Action. Verity disputes Federal's assertion.

26. An actual controversy exists between Verity and Federal, regarding the respective rights and obligations of the Oden Defendants under the Federal Policies in connection with the *Oden* Action. Verity requests a judicial declaration that Federal has a duty to indemnify the Oden Defendants and any other person or entity qualifying as an insured under the Federal Policies in the *Oden* Action. Such a judicial declaration is necessary and proper at this time so that the parties will be bound by the same interpretation of the Federal Policies and adjudication of their rights and obligations thereunder.

//

THIRD CLAIM FOR RELIEF

Breach of Contract

27. Verity re-alleges and incorporates herein by reference each and every allegation and statement set forth in the preceding Paragraphs 1 through 26, as though each was fully set forth herein.

28. The Federal Policies provide coverage for the Oden Defendants pertaining to the *Oden* Action.

29. The Oden Defendants complied with all requirements under the Federal Policies, including promptly tendering the *Oden* Action to Federal.

30. Federal breached the Federal Policies when it wrongfully refused to defend or indemnify the Oden Defendants for the *Oden* Action, failed to conduct a thorough, complete, or fair investigation of the claim, and ignored key evidence presented to Federal pertaining to the claim.

31. As a consequence of Federal's breach of the Federal Policies, Verity has sustained compensatory damages in a sum to be determined according to proof.

FOURTH CLAIM FOR RELIEF

Breach of the Implied Covenant of Good Faith and Fair Dealing

32. Verity re-alleges and incorporates herein by reference each and every allegation and statement set forth in the preceding Paragraphs 1 through 31, as though each was fully set forth herein.

33. Federal owes the Oden Defendants a duty of good faith and fair dealing pursuant to the Federal Policies.

34. Federal breached the duty of good faith and fair dealing owed to the Oden Defendants with respect to the *Oden* Action when Federal: (a) Elevated its interests above the interests of the Oden Defendants; (b) Failed to conduct a thorough, complete, or fair investigation of the claim; (c) Failed to evaluate the Oden Defendants' claim objectively, including ignoring key evidence pertaining to the claim; (d) Applied unduly restrictive and unreasonable interpretations of the

Federal Policies as an excuse for denying policy benefits to the Oden Defendants; (e) deliberately denied benefits that Federal knew were owed under the Federal Policies for the *Oden* Action; (f) Misrepresented facts and conclusions learned as a result of its inadequate investigation; and (g) unreasonably forced Verity to institute litigation to compel Federal to comply with its obligations under the Federal Policies.

35. As a result of Federal's breach of its duty of good faith and fair dealing to the Oden Defendants, Verity has and will continue to incur substantial damages, including *Brandt* fees.

36. Federal is guilty of oppression, fraud, and/or malice such that punitive damages are warranted under California Civil Code Section 3294.

37. Verity is entitled to recover all damages proximately caused by or attributed to Federal's unreasonable conduct, the amount of which will be determined according to proof.

PRAYER FOR RELIEF

WHEREFORE, Verity prays for judgment as follows:

1. First Claim: For a declaration and judgment, binding on all parties to this action, that Federal has a duty under the Federal Policies to defend the Oden Defendants and any other person or entity qualifying as an insured under the Federal Policies in the *Oden* Action;

2. Second Claim: For a declaration and judgment, binding on all parties to this action, that Federal has a duty under the Federal Policies to indemnify the Oden Defendants and any other person or entity qualifying as an insured under the Federal Policies in the *Oden* Action;

3. Third Claim: For compensatory damages, including unreimbursed attorneys' fees, costs, and expenses, including interest thereon, incurred in defending the Oden Defendants in the *Oden* Action; and for such other or further relief as the Court deems just and proper;

4. Fourth Claim: For compensatory damages, including *Brandt* fees, including interest thereon; punitive damages; and for such other and further relief as the Court may deem just and proper.

DATED: May 29, 2026

MUSICK, PEELER & GARRETT LLP

By: */s/ Isis D. Miranda*
Isis D. Miranda
Attorneys for Plaintiff
VHS LIQUIDATING TRUST, liquidating trust for Verity Health System of California, Inc. (formerly known as Daughters of Charity Health System)

B1040 (FORM 1040) (12/24)

ADVERSARY PROCEEDING COVER SHEET (Instructions on Reverse)	**ADVERSARY PROCEEDING NUMBER** (Court Use Only)

PLAINTIFFS	**DEFENDANTS**
VHS Liquidating Trust	Federal Insurance Company
ATTORNEYS (Firm Name, Address, and Telephone No.) Musick Peeler & Garrett, LLP 333 S. Hope Street, Suite 2900 Los Angeles, CA 90071	**ATTORNEYS** (If Known)
PARTY (Check One Box Only) □ Debtor □ U.S. Trustee/Bankruptcy Admin □ Creditor ☒ Other Liquidating Trust for Debtor in Possession □ Trustee	**PARTY** (Check One Box Only) □ 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)
This is an insurance coverage action in which the liquidating trust for the debtor in possession seeks declaratory judgments (28 U.S.C. sections 2201 and 2202) providing that its insurance company must defend and indemnify it in an dversary action, as well as compensatory damages. The asserted causes of action include: (1) Declaratory Judgment Re Duty to Defend; (2) Declaratory Judgment Re Duty to Indemnify; (3) Breach of Contract; and (4) Breach of Implied Covenant of Good Faith and Fair Dealing.

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
- ☐ 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
- ☐ 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)

☒ 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 $20,000,000
Other Relief Sought	

B1040 (FORM 1040) (12/24)

BANKRUPTCY CASE IN WHICH THIS ADVERSARY PROCEEDING ARISES		
NAME OF DEBTOR Verity Health System of California, Inc., et al.	BANKRUPTCY CASE NO. 2:18-bk-20151-BB	
DISTRICT IN WHICH CASE IS PENDING California Central Bankruptcy Court	DIVISION OFFICE Los Angeles Division	NAME OF JUDGE Sheri Bluebond
RELATED ADVERSARY PROCEEDING (IF ANY)		
PLAINTIFF Rachel Oden	DEFENDANT Richard G. Adcock, et al.	ADVERSARY PROCEEDING NO. 2:26-ap-01044-BB
DISTRICT IN WHICH ADVERSARY IS PENDING California Central Bankruptcy Court	DIVISION OFFICE Los Angeles	NAME OF JUDGE Sheri Bluebond
SIGNATURE OF ATTORNEY (OR PLAINTIFF) */s/ Isis D. Miranda*		
DATE May 29, 2026	PRINT NAME OF ATTORNEY (OR PLAINTIFF) Isis D. Miranda	

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.

UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*, Debtors and Debtors In Possession.	Lead Case No. 2:18-bk-20151-ER Jointly Administered With: CASE NO.: 2:18-bk-20162-ER CASE NO.: 2:18-bk-20163-ER CASE NO.: 2:18-bk-20164-ER CASE NO.: 2:18-bk-20165-ER CASE NO.: 2:18-bk-20167-ER CASE NO.: 2:18-bk-20168-ER CASE NO.: 2:18-bk-20169-ER CASE NO.: 2:18-bk-20171-ER CASE NO.: 2:18-bk-20172-ER CASE NO.: 2:18-bk-20173-ER CASE NO.: 2:18-bk-20175-ER CASE NO.: 2:18-bk-20176-ER CASE NO.: 2:18-bk-20178-ER CASE NO.: 2:18-bk-20179-ER CASE NO.: 2:18-bk-20180-ER CASE NO.: 2:18-bk-20181-ER Chapter 11 Cases Hon. Judge Ernest M. Robles
☒ Affects All Debtors ☐ Affects Verity Health System of California, Inc. ☐ Affects O'Connor Hospital ☐ Affects Saint Louise Regional Hospital ☐ Affects St. Francis Medical Center ☐ Affects St. Vincent Medical Center ☐ Affects Seton Medical Center ☐ Affects O'Connor Hospital Foundation ☐ Affects Saint Louise Regional Hospital Foundation ☐ Affects St. Francis Medical Center of Lynwood Foundation ☐ Affects St. Vincent Foundation ☐ Affects St. Vincent Dialysis Center, Inc. ☐ Affects Seton Medical Center Foundation ☐ Affects Verity Business Services ☐ Affects Verity Medical Foundation ☐ Affects Verity Holdings, LLC ☐ Affects De Paul Ventures, LLC ☐ Affects De Paul Ventures - San Jose ASC, LLC Debtors and Debtors In Possession.	**MODIFIED SECOND AMENDED JOINT CHAPTER 11 PLAN OF LIQUIDATION (DATED JULY 2, 2020) OF THE DEBTORS, THE PREPETITION SECURED CREDITORS, AND THE COMMITTEE** Plan Confirmation Hearing: Date: August 12, 2020 Time: 10:00 a.m. (Pacific Time) Place: Courtroom 1568 255 E. Temple Street Los Angeles, CA 90012

1820151200812000000000001

SAMUEL R. MAIZEL (Bar No. 189301)
samuel.maizel@dentons.com
TANIA M. MOYRON (Bar No. 235736)
tania.moyron@dentons.com
NICHOLAS A. KOFFROTH (Bar No. 287854)
nicholas.koffroth@dentons.com
DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, California 90017-5704
Tel: (213) 623-9300 / Fax: (213) 623-9924

Attorneys for the Chapter 11 Debtors and Debtors In Possession

PAUL J. RICOTTA (admitted *pro hac vice*)
pricotta@mintz.com
DANIEL S. BLECK (admitted *pro hac vice*)
dsbleck@mintz.com
MINTZ, LEVIN, COHN, FERRIS, GLOVSKY AND POPEO, P.C.
One Financial Center
Boston, Massachusetts 02111
Tel: (617) 542-6000 / Fax: (617) 542-2241

Attorneys for UMB Bank, N.A., as Master Indenture Trustee and Wells Fargo Bank, National Association, as Indenture Trustee

NATHAN F. COCO (admitted *pro hac vice*)
ncoco@mwe.com
MEGAN M. PREUSKER (admitted *pro hac vice*)
mpreusker@mwe.com
MCDERMOTT WILL & EMERY LLP
444 West Lake Street
Chicago, Illinois 60606-0029
Tel: (312) 372-2000 / Fax: (312) 948-7700

Attorneys for U.S. Bank National Association solely in its capacity, as the note indenture trustee and as the collateral agent under the note indenture relating to the 2015 Working Capital Notes

CLARK T. WHITMORE (admitted *pro hac vice*)
clark.whitmore@maslon.com
JASON REED (admitted *pro hac vice*)
jason.reed@maslon.com
MASLON LLP
90 South Seventh Street
Minneapolis, Minnesota 55402-4140
Tel: (312) 372-2000 / Fax: (312) 948-7700

Attorneys for U.S. Bank National Association solely in its capacity, as the note indenture trustee and as the collateral agent under the note indenture relating to the 2017 Working Capital Notes

BRUCE S. BENNETT (Bar No. 105430)
bbennett@jonesday.com
BENJAMIN ROSENBLUM (admitted *pro hac vice*)
brosenblum@jonesday.com
PETER S. SABA (admitted *pro hac vice*)
psaba@jonesday.com
JONES DAY LLP
250 Vesey Street
New York, New York 10281
Tel: (212) 326-3939 / Fax: (212) 755-7306

Attorneys for Verity MOB Financing, LLC and Verity MOB Financing II, LLC

GREGORY A. BRAY (Bar No. 115367)
gbray@milbank.com
MARK SHINDERMAN (Bar No. 136644)
mshinderman@milbank.com
JAMES C. BEHRENS (Bar No. 280365)
jbehrens@milbank.com
MILBANK LLP
2029 Century Park East
33rd Floor
Los Angeles, California 90067
Tel: (424) 386-4000 / Fax: (213) 629-5063

Attorneys for the Official Committee of Unsecured Creditors

Table of Contents

SECTION 1. DEFINITIONS AND INTERPRETATION 2

A. Definitions 2

B. Interpretation and Rules of Construction 21

C. Controlling Document 22

SECTION 2. ADMINISTRATIVE EXPENSE AND PRIORITY CLAIMS. 22

2.1 ***Administrative Claims*** 22

2.2 ***Professional Claims*** 22

2.3 ***Statutory Fees*** 23

2.4 ***Priority Tax Claims*** 23

SECTION 3. CLASSIFICATION OF CLAIMS 23

3.1 ***Classification in General*** 23

3.2 ***Grouping of Debtors for Deemed Substantive Consolidation*** 23

3.3 ***Summary of Classification*** 24

3.4 ***Special Provision Governing Unimpaired Claims*** 24

3.5 ***Elimination of Vacant Classes*** 24

SECTION 4. TREATMENT OF CLAIMS 25

4.1 ***Class 1A: Priority Non-Tax Claims*** 25

4.2 ***Class 1B: Secured PACE Tax Financing Claims*** 25

4.3 ***Class 2: Secured 2017 Revenue Notes Claims*** 25

4.4 ***Class 3: Secured 2015 Revenue Notes Claims*** 26

4.5 ***Class 4: Secured 2005 Revenue Bond Claims*** 26

4.6 ***Class 5: Secured MOB I Financing Claims*** 27

4.7 ***Class 6: Secured MOB II Financing Claims*** 28

4.8 ***Class 7: Secured Mechanics Lien Claims*** 28

4.9 ***Class 8: General Unsecured Claims*** 28

4.10 ***Class 9: Insured Claims*** 28

4.11 ***Class 10: 2016 Data Breach Claims*** 30

4.12 ***Class 11: Subordinated General Unsecured Claims*** 30

4.13 ***Class 12: Interests*** 30

SECTION 5. POST-EFFECTIVE DATE GOVERNANCE 30

5.1 ***Dissolution of Certain Debtors*** 30
5.2 ***Dissolution of Certain Non-Debtor Affiliates*** 30
5.3 ***Dissolution of Sale-Leaseback Debtor Foundations*** 31
5.4 ***Dissolution of the SCC Debtor Foundations*** 31
5.5 ***Dissolution of St. Vincent Foundation*** 31
5.6 ***Dissolution of VMF*** 31
5.7 ***Disposition of Marillac*** 31
5.8 ***Continued Existence of Post-Effective Date Debtors After the Effective Date*** 32
5.9 ***Post-Effective Date Board of Directors*** 34
5.10 ***Document Preservation*** 35
SECTION 6. THE LIQUIDATING TRUST 35
6.1 ***Creation*** 35
6.2 ***Purposes of the Liquidating Trust*** 35
6.3 ***The Liquidating Trust Agreement*** 36
6.4 ***Operations of the Liquidating Trust*** 36
6.5 ***Liquidating Trustee*** 36
6.6 ***Books and Records*** 40
6.7 ***Payment of Trust Expenses*** 40
6.8 ***Employment and Compensation of Professionals*** 40
6.9 ***Limitation of Liability of the Liquidating Trustee and the Post-Effective Date Committee*** 41
6.10 ***Termination of the Trust*** 41
SECTION 7. MEANS FOR IMPLEMENTATION OF THE PLAN 42
7.1 ***Creditor Settlement Agreements*** 42
7.2 ***Deemed Substantive Consolidation*** 45
7.3 ***Cancellation of Existing Indentures and Related Securities*** 46
7.4 ***Funding for Distributions*** 46
7.5 ***No Further Court Authorization*** 46
7.6 ***Operating Accounts for the Post-Effective Date Debtors*** 47
7.7 ***Transfer of Certain Funds Into the Liquidating Trust*** 47
7.8 ***Funding of the Liquidating Trust Administration Accounts*** 49
7.9 ***Liquidating Trust Reserves*** 49

7.10 ***Plan Fund*** 50
7.11 ***Post-Effective Date Committee*** 51
7.12 ***Coordination Between Post-Effective Date Debtors and the Liquidating Trust*** 52
7.13 ***Destruction and Abandonment of Books and Records*** 52
7.14 ***Preservation of Insurance*** 53
7.15 ***Mutuality preserved*** 53
SECTION 8. DISTRIBUTIONS 53
8.1 ***Party Responsible for Making Distributions*** 53
8.2 ***Appointment of Disbursing Agent*** 53
8.3 ***Timing of Distributions*** 53
8.4 ***Withholding of Distributions*** 53
8.5 ***Delivery of Distributions and Undeliverable Distributions*** 54
8.6 ***Setoffs*** 54
8.7 ***De Minimis Distributions*** 55
8.8 ***Allocation of Plan Distribution Between Principal and Interest*** 55
8.9 ***Entry of Final Decree in Chapter 11 Cases*** 55
SECTION 9. TRUST BENEFICIARIES 55
9.1 ***Identification of Trust Beneficiaries*** 55
9.2 ***Beneficial Interests Only*** 55
9.3 ***Ownership of Beneficial Interests Hereunder*** 56
9.4 ***Evidence of Beneficial Interests*** 56
9.5 ***Conflicting Claims*** 56
9.6 ***Limitation on Transferability*** 56
SECTION 10. PROCEDURES FOR TREATING AND RESOLVING DISPUTED CLAIMS 56
10.1 ***Objection to Claims*** 56
10.2 ***Disallowed Claims*** 57
10.3 ***No Distribution Pending Allowance*** 57
10.4 ***Distributions After Allowance*** 57
10.5 ***Disputed Claims*** 57
10.6 ***Cumulative Effect*** 58
SECTION 11. EXECUTORY AGREEMENTS 58

11.1 ***General Treatment*** 58
11.2 ***Bar Date for Rejection Damages*** 59
11.3 ***Insurance Policies*** 59
SECTION 12. CONDITIONS PRECEDENT TO EFFECTIVE DATE 60
12.1 ***Conditions Precedent to Confirmation of Plan*** 60
12.2 ***Conditions to Effective Date*** 60
12.3 ***Waiver of Conditions*** 60
SECTION 13. EFFECT OF CONFIRMATION 60
13.1 ***Vesting of Assets*** 60
13.2 ***No Discharge*** 61
13.3 ***Settlement of Causes of Action Relating to Claims*** 61
13.4 ***Extension of Existing Injunctions and Stays*** 61
13.5 ***Releases*** 61
13.6 **Injunctions** 62
13.7 ***Exculpation*** 63
13.8 ***No Recourse*** 64
13.9 ***Preservation of Causes of Action*** 64
13.10 ***Termination of Responsibilities of the Patient Care Ombudsman*** 66
13.11 ***SGM Action*** 66
SECTION 14. RETENTION OF JURISDICTION 66
14.1 ***Bankruptcy Court Jurisdiction*** 66
SECTION 15. MISCELLANEOUS PROVISIONS 68
15.1 ***Termination of All Employee, Retiree and Workers' Compensation Benefits*** 68
15.2 ***Termination of Collective Bargaining Agreements*** 69
15.3 ***Administrative Claims Bar Date*** 69
15.4 ***Exemption from Transfer Taxes*** 69
15.5 ***Amendments*** 69
15.6 ***Revocation or Withdrawal of Plan*** 70
15.7 ***Severability*** 70
15.8 ***Request for Expedited Determination of Taxes*** 70
15.9 ***U.S. Trustee Quarterly Fees and Post-Confirmation Status Reports*** 70

15.10 ***Courts of Competent Jurisdiction*** 70
15.11 ***Governing Law*** 71
15.12 ***Continuing Effect of the Bankruptcy Court Orders and Settlement Stipulations*** 71
15.13 ***Time*** 71
15.14 ***Business Day Transactions*** 71
15.15 ***Headings*** 71
15.16 ***Exhibits*** 71
15.17 ***Notices*** 71
15.18 ***Post-Effective Date Notices*** 73
15.19 ***Conflict of Terms*** 73

INTRODUCTION[1]

The Debtors, the Prepetition Secured Creditors, and the Committee propose the following amended chapter 11 plan (as further defined below, the "***Plan***"), pursuant to § 1121(a) of the Bankruptcy Code.[2] Creditors should refer to the Disclosure Statement filed or to be filed in connection with this Plan, including the exhibits thereto, for a discussion of the Debtors' history, business, properties, results of operations, and future projections and risk factors, together with a summary and analysis of this Plan.

The Plan proposes to pay Allowed Secured Claims and Allowed Administrative Claims in full on the Effective Date except for the 2005 Bonds Diminution Claim, payment of which will be deferred post-Effective Date to allow for the payment of the foregoing Claims in exchange for, among other things, (i) the dismissal of certain litigation commenced by the Committee, and (ii) the waiver of challenge claims preserved against Verity MOB Financing LLC and Verity MOB Financing II LLC under the Final DIP Order and the Cash Collateral Orders. The Plan also proposes the resolution of certain other Claims and the distribution of proceeds to Holders of Allowed Claims. Claims against the Debtors—other than Unclassified Claims—are classified in Section 3 and treated in accordance with Section 4 hereof.[3] The Plan provides that a Liquidating Trustee will continue the wind-down and liquidation of the Debtors after the Effective Date, and will oversee the operations of the Post-Effective Date Debtors during the Sale Leaseback Period in accordance with the Interim Agreements and the Transition Services Agreements.

The Plan requests the Bankruptcy Court approve and implement the terms of (i) the Creditor Settlement Agreements, including the Plan Settlement, and (ii) all documents necessary to effectuate the Plan. To the extent that there are any inconsistencies between the terms of the Creditor Settlement Agreements, the Interim Agreements, the Transition Services Agreements and/or the Plan or Confirmation Order, unless otherwise expressly provided for in such Creditor Settlement Agreements, Interim Agreements, Transition Services Agreements and/or the Plan, the terms of this Plan shall govern. In the event of a conflict between the Plan and Confirmation Order, the Confirmation Order shall govern.

NO SOLICITATION MATERIALS, OTHER THAN THE DISCLOSURE STATEMENT AND RELATED MATERIALS TRANSMITTED THEREWITH AND APPROVED BY THE COURT, HAVE BEEN AUTHORIZED BY THE COURT FOR USE IN SOLICITING ACCEPTANCES OR REJECTION OF THIS PLAN. ALL HOLDERS OF CLAIMS ARE ENCOURAGED TO READ THE PLAN AND DISCLOSURE STATEMENT IN THEIR ENTIRETY BEFORE VOTING TO ACCEPT OR REJECT THE PLAN.

---

1 Capitalized terms not otherwise defined in this Introduction have the definitions set forth in Section 1 of this Plan.

2 All references to "§" herein are to the Bankruptcy Code, unless otherwise noted.

3 All references to "Article" and "Section" herein are to the articles and sections of this Plan unless otherwise noted.

SECTION 1. DEFINITIONS AND INTERPRETATION

A. Definitions. The following terms used herein shall have the respective meanings defined below (such meanings to be equally applicable to both the singular and plural):

1.1 ***2005 Revenue Bonds Diminution Claim*** means that portion of the Secured 2005 Revenue Bonds Claim (as more fully described and calculated in accordance with Section 4.5(b) below) which remains unpaid after payment on the Effective Date of (i) an amount equal to the Initial Secured 2005 Revenue Bonds Claims Payment, plus (ii) the amounts applied by the 2005 Revenue Bonds Trustee to the Secured 2005 Revenue Bonds Claim which are held in a (1) principal or revenue account, (2) debt service or redemption reserve, or (3) an escrow or expense reserve account, plus (iii)(a) accrued, but unpaid postpetition interest, if any, at the rate specified in the 2005 Revenue Bond Indentures through and including the Effective Date, excluding any interest at the default rate or the Tax Rate, or any applicable redemption or other premium, and (b) any accrued, but unpaid reasonable, necessary out-of-pocket fees and expenses of the 2005 Revenue Bonds Trustee and the Master Trustee pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date. The 2005 Revenue Bonds Diminution Claim shall be in an amount no greater than $135,245,000.00, plus interest, to be paid after the Effective Date, pursuant to Section 4.5 hereof and the Plan Settlement.

1.2 ***2005 Revenue Bonds Trustee*** means Wells Fargo Bank, National Association, as trustee for those certain bonds issued pursuant to the 2005 Revenue Bonds Indentures.

1.3 ***2005 Series A, G and H Revenue Bonds*** means those series of outstanding bonds issued by the CSCDA, pursuant to the terms of the 2005 Revenue Bonds Indentures.

1.4 ***2005 Revenue Bonds Indentures*** means those certain bond indentures, dated as of February 1, 2005, as amended and supplemented, between the CSCDA and the 2005 Revenue Bonds Trustee, supported by the Obligations arising in connection with those certain Loan Agreements, dated February 1, 2005, between the Daughters of Charity Health System and CSCDA, and secured by the collateral pledged to the Master Trustee for the benefit of the Series A, G and H Revenue Bonds.

1.5 ***2015 Notes Trustee*** means U.S. Bank, National Association, solely in its capacity as trustee for those certain notes issued pursuant to the 2015 Revenue Notes Indentures.

1.6 ***2015 Revenue Notes*** means those outstanding Series A, B, C and D notes issued by the CPFA, pursuant to the terms of the 2015 Revenue Notes Indentures.

1.7 ***2015 Revenue Notes Indentures*** means those certain note indentures, dated as of December 1, 2015, between the CPFA and the 2015 Notes Trustee, supported by the Obligations arising in connection with those certain Loan Agreements, dated as of December 1, 2015, between VHS and CPFA, and secured by the collateral pledged to the Master Trustee for the benefit of the 2015 Revenue Notes.

1.8 ***2016 Data Breach Claims*** means all timely filed Claims for damages asserted by any individual whose personally identifiable information was disclosed, in the data breach

occurring on April 27, 2016, and subject to the extended Bar Date set forth in the Bankruptcy Court's order [Docket No. 2434].

1.9 ***2017 Notes Trustee*** means U.S. Bank, National Association, solely in its capacity,\ as trustee for those certain notes issues pursuant to the 2017 Revenue Notes Indentures, dated as of December 1, 2017, pursuant to the 2017 Revenue Notes Indentures.

1.10 ***2017 Revenue Notes*** means those outstanding Series A, B, C and D notes issued by the CPFA, pursuant to the terms of the 2017 Revenue Notes Indentures.

1.11 ***2017 Revenue Notes Indenture*s** means those certain note indentures, dated as of December 1, 2017, between the CPFA and the 2017 Notes Trustee, supported by the Obligations arising in connection with those certain Loan Agreements, dated as of December 1, 2017, between VHS and CPFA and secured by the collateral pledged to the Master Trustee for the benefit of the 2017 Revenue Notes.

1.12 ***Adequate Protection Payments*** means any and all payments made by the Debtors prior to the Effective Date to or for the benefit of the Prepetition Secured Creditors pursuant to the section 5(b) of Final DIP Order and/or the Cash Collateral Orders.

1.13 ***Administrative Claim*** means a Request for Payment of an administrative expense of a kind specified in § 503(b) and entitled to priority pursuant to § 507(a)(2), including, but not limited to, the actual, necessary costs and expenses, incurred on or after the Petition Date, of preserving the Estates and operating the business of the Debtors, including wages, salaries, or commissions for services rendered after the commencement of the Chapter 11 Cases, Section 503(b)(9) Claims, and Allowed Claims that are entitled to be treated as Administrative Claims pursuant to a Final Order of the Bankruptcy Court (under § 546(c)(2)(A) or otherwise), but excluding Professional Claims, and Statutory Fees, which are separately defined below.

1.14 ***Administrative Claims Bar Date*** means the deadline set by an order of the Bankruptcy Court by which holders of Administrative Claims, other than Administrative Claims arising in the ordinary course of business for the Debtors, must assert Administrative Claims or be forever barred, which shall be not less than 14 days prior to the date of the Confirmation Hearing.

1.15 ***Administrative Claims Reserve*** means Cash to be set aside by the Debtors on the Effective Date in an aggregate amount sufficient to fund a reserve for the payment of all unpaid Allowed Administrative Claims that will be paid after the Effective Date and all Administrative Claims that are not yet Allowed as of the Effective Date. The amount of such reserve shall be determined and approved by the Bankruptcy Court at the Confirmation Hearing in accordance with the procedures established in Section 15.3.

1.16 ***AHMC*** means AHMC Healthcare Inc., or its designee under the Seton Asset Purchase Agreement.

1.17 ***Allowed*** means for distribution purposes, a Claim, or any portion thereof, or a particular Class of Claims (a) that is Allowed by a Final Order of the Bankruptcy Court (or such other court as provided by the Plan or as the Liquidating Trustee and the Holder of such Claim agree may adjudicate such Claim and objections thereto), (b) that is Allowed by this Plan and/or

Confirmation Order, (c) which is not the subject of a Proof of Claim timely filed with the Bankruptcy Court and is Scheduled as liquidated and noncontingent (other than a Claim that is Scheduled at zero, in an unknown amount, or as disputed), but only to the extent such Claim is Scheduled as liquidated and noncontingent, (d) for which a Proof of Claim in a liquidated amount has been timely filed with the Bankruptcy Court pursuant to the Bankruptcy Code or deemed timely filed by any Final Order of the Bankruptcy Court or other applicable bankruptcy law, and as to which (i) no objection to its allowance has been filed within the periods of limitation fixed by the Plan, the Bankruptcy Code, or by any order of the Bankruptcy Court, (ii) any objection to its allowance has been settled or withdrawn, or has been denied by a Final Order of the Bankruptcy Court, or, (iii) following the Effective Date, with respect to General Unsecured Claims, as otherwise may be determined by the Liquidating Trust in accordance with the Plan and the Liquidating Trust Agreement, or (d) that is expressly allowed in a liquidated amount pursuant to this Plan.

1.18 ***Assets*** means all legal or equitable interests of the Estates in any and all (a) property of every kind, nature, character and description, whether real, personal, or mixed, whether tangible or intangible (including contract rights), wherever situated and by whomever possessed, and any goodwill related thereto, including any real estate, buildings, structures, improvements, privileges, rights, easements, leases, subleases, goods, materials, supplies, furniture, fixtures, equipment, work in process, accounts, chattel paper, cash (including, but not limited to, cash of the Foundations that is not properly donor-restricted), deposit accounts, reserves, deposits, contractual rights, intellectual property rights, claims, Causes of Action, securities, investments and any other general intangibles, and (b) the proceeds, products, offspring, rents or profits thereof, including all assets of any of the Debtors constituting "property of the estate" as described in § 541.

1.19 ***Avoidance Actions*** means any Causes of Action arising under any section of chapter 5 of the Bankruptcy Code, including, without limitation, §§ 502, 510, 541, 542, 543, 544, 545, 547, 548, 549, 550, 551, and 553 or under similar or related state or federal statutes and common law, including state fraudulent transfer laws.

1.20 ***Ballot Deadline*** means the date all Ballots must be properly executed, completed and delivered by First Class Mail, overnight courier, or hand delivery, to KCC, at 222 N. Pacific Coast Highway, 3rd Floor, El Segundo, CA 90245, so as to be actually received by KCC no later than 4:00 p.m. (Pacific Time), on the date set by the Bankruptcy Court in the Disclosure Statement Order.

1.21 ***Bankruptcy Code*** means title 11 of the United States Code, 11 U.S.C. §§ 101, *et seq.*, as amended.

1.22 ***Bankruptcy Court*** means the United States Bankruptcy Court for the Central District of California, except to the extent the jurisdictional reference of the Bankruptcy Court has been withdrawn to the United States District Court for the Central District of California, pursuant to section 157(d) of title 28 of the United States Code.

1.23 ***Bankruptcy Rules*** means the Federal Rules of Bankruptcy Procedure as promulgated by the United States Supreme Court under section 2075 of title 28 of the United States Code, as may be amended from time to time.

1.24 ***Bar Date*** means the applicable deadlines by which a Proof of Claim or Request for Payment must be, or must have been, filed in these Chapter 11 Cases, as established by either an order of the Bankruptcy Court or this Plan, including without limitation, (a) the April 1, 2019, deadline to file Proofs of Claim relating to prepetition Claims, (b) the September 30, 2019 extended deadline for 2016 Data Breach Claims, (c) the October 11, 2019 extended deadline for certain wage and hour claims pursuant to the *Order Approving Notice of Extended Bar Date re Certain Wage and Hour Claims* [Docket No. 2692], and (d) the Administrative Claims Bar Date..

1.25 ***Bar Date Order*** means any order of the Bankruptcy Court establishing Bar Dates for filing Proofs of Claim or Requests for Payment in these Chapter 11 Cases, as the same may be amended, modified or supplemented including, but not limited to, those orders at Docket Nos. 1528, 2434, 2435, 2436, 2537, and 2692.

1.26 ***Bond and Notes Trustee(s)*** means all or any of the 2005 Revenue Bonds Trustee, the 2015 Notes Trustee and the 2017 Revenue Notes Trustee, as the context requires.

1.27 ***Business Day*** means any day other than a Saturday, a Sunday, or any other day on which banking institutions in the State of California are required or authorized to close by law or executive order.

1.28 ***Cash*** means the legal tender of the United States of America and its equivalent.

1.29 ***Cash Collateral Orders*** means, collectively, the orders authorizing use of cash collateral entered under Docket Nos. 3022, 3883, 4028, 4187, and 4670, and any subsequent orders authorizing the use of cash collateral, the terms of which may be agreed to between the Debtors and the Prepetition Secured Creditors.

1.30 ***Causes of Action*** means any and all present or future claims, rights, legal and equitable defenses, offsets, recoupments, actions in law or equity or otherwise, choses in action, obligation, guaranty, controversy, demand, action suits, damages, judgments, third-party claims, counter-claims, cross-claims against any Person, whether known or unknown, liquidated or unliquidated, foreseen or unforeseen, existing or hereafter arising, whether based on legal or equitable relief, whether arising under the Bankruptcy Code or federal, state, common, or other law or equity, whether or not the subject of a pending litigation or proceedings on the Effective Date or thereafter, including without limitation: (a) all Avoidance Actions; (b) all other claims in avoidance, recovery, and/or subordination; (c) all SGM Claims; (d) all claims against Integrity Healthcare, LLC and BlueMountain Capital Management LLC; and (e) all other actions described in the Disclosure Statement, the Confirmation Order, the Schedules, or the Plan; provided, however, (x) any claims arising under the Interim Agreements and (y) any claims or other litigation compromised as part of a Creditor Settlement Agreement, are, in each case, excluded.

1.31 ***CDPH*** means the California Department of Public Health.

1.32 ***Chapter 11 Cases*** means the voluntary cases commenced by each of the Debtors under chapter 11 of the Bankruptcy Code on the Petition Date and administered jointly under caption, *In re Verity Health System of California, Inc., et al.*, Lead Case No. 2:18-bk-20151-ER, which are currently pending before the Bankruptcy Court. Unless otherwise noted, all references to a docket or docket entry herein refer to the docket of the Lead Case.

1.33 ***Claim*** has the meaning set forth in § 101(5).

1.34 ***Claims Objection Deadline*** means the first Business Day that is the later of (a) two hundred ten (210) days after the Effective Date, or (b) such other later date as the Bankruptcy Court may establish upon a motion by the Liquidating Trustee in accordance with the Plan.

1.35 ***Class*** means a class of Claims established pursuant to Section 4 herein.

1.36 ***CMS*** means Centers for Medicare and Medicaid Services.

1.37 ***Committee*** means the Official Committee of Unsecured Creditors appointed on September 17, 2018, by the U.S. Trustee in these Chapter 11 Cases pursuant to § 1102 [Docket No. 197].

1.38 ***Confirmation Date*** means the date on which the Clerk of the Bankruptcy Court enters the Confirmation Order on the docket of the Lead Case.

1.39 ***Confirmation Hearing*** means the hearing to be held by the Bankruptcy Court to consider confirmation of the Plan, as such hearing may be adjourned or continued from time to time.

1.40 ***Confirmation Order*** means the order of the Bankruptcy Court confirming this Plan pursuant to § 1129.

1.41 ***Consent*** means consent of a party that is not to be unreasonably withheld or delayed.

1.42 ***CPFA*** means the California Public Financing Authority.

1.43 ***Creditor Settlement Agreements*** mean, collectively, any settlements that the Debtors enter into with creditors to resolve Causes of Action, claims, and/or litigation in connection with or relating to the Plan, which shall be filed seven (7) days prior to the Ballot Deadline, if not earlier, as a Plan Supplement, unless such deadline shall otherwise be extended with the consent of the Plan Proponents, which shall not be unreasonably withheld or delayed.

1.44 ***Creditor Settlement Parties*** means, collectively, parties to Creditor Settlement Agreements.

1.45 ***CSCDA*** means the California Statewide Communities Development Authority.

1.46 ***Debtors*** means, collectively, VHS and its sixteen affiliates, listed on Schedule 1.41 hereto, in their capacity as debtors and debtors in possession in these Chapter 11 Cases.

1.47 ***Defined Contribution Plans*** means, collectively, the qualified and non-qualified 401(a), 401(k), 403(b), and 457(b) defined contribution plans maintained by certain Debtors.

1.48 ***DePaul Ventures*** means DePaul Ventures, LLC, a debtor and debtor in possession.

1.49 ***DePaul - San Jose ASC*** means De Paul Ventures - San Jose ASC, LLC, a Non-Debtor Affiliate.

1.50 ***DePaul - San Jose Dialysis*** means DePaul Ventures - San Jose Dialysis, LLC, a debtor and debtor in possession.

1.51 ***DHC*** means California Department of Health Care Service.

1.52 ***DHHS*** means the United States Department of Health and Human Services.

1.53 ***Disallowed*** means, with respect to any Claim or Interest, any Claim or Interest (i) proof of which was required to be filed by the Bankruptcy Code or an order of the Bankruptcy Court, but as to which no proof of Claim or Interest was timely or properly filed, (ii) which has been withdrawn in whole or in part, by an agreement between the Debtors or the Trust and the Holder thereof or unilaterally by the Holder thereof, or (iii) which has been disallowed, in whole or in part, by a Final Order or pursuant to this Plan. In the event that a Claim is disallowed in part, then the Claim may be an Allowed Claim with respect to amounts asserted under the Claim which have not been disallowed.

1.54 ***District Court*** means the United States District Court for the Central District of California.

1.55 ***Disclosure Statement*** means the disclosure statement filed with the Bankruptcy Court by the Debtors, pursuant to § 1125, with respect to the Plan, including all exhibits and schedules thereto, which was approved by the Bankruptcy Court pursuant to § 1125, as it may be amended, modified or supplemented from time to time.

1.56 ***Disbursing Agent*** means KCC in its capacity as a disbursing agent under Section 8 hereof.

1.57 ***Disputed*** means, with respect to any Claim:

(a) if no Proof of Claim has been filed by the applicable Bar Date, a Claim that is:

(i) listed on the Schedules as either disputed, contingent, or unliquidated; or

(ii) subject to an objection or a request for estimation that has been filed by the Claims Objection Deadline and has not been withdrawn or determined by a Final Order; or

(b) if a Proof of Claim has been filed by the applicable Bar Date, a Claim as to which:

(i) no corresponding Claim is listed on the Schedules;

(ii) a corresponding Claim is listed on the Schedules as disputed, contingent, or unliquidated;

(iii) a corresponding Claim is listed on the Schedules not as disputed, contingent, or unliquidated, but the nature or amount of the Claim as asserted in the Proof of Claim varies from the nature and amount of such Claim as listed on the Schedules; or

(iv) an objection or a request for estimation has been interposed by the Claims Objection Deadline that, in either instance, has not been withdrawn or determined pursuant to a Final Order.

1.58 ***Disputed Unclassified Claims*** means Unclassified Claims that are Disputed.

1.59 ***Disputed Unsecured Claims Reserve*** means the reserve for Disputed General Unsecured Claims established under Section 7.9(c) hereof.

1.60 ***Effective Date*** means a day, as determined by the Plan Proponents, that is a Business Day as soon as reasonably practicable after all conditions to the Effective Date specified in Section 12.2 hereof have been satisfied or waived.

1.61 ***Effective Date Professional Claim Reserves.*** Cash to be set aside by the Liquidating Trustee on the Effective Date sufficient in the aggregate to fund a reserve on account of Professional Claims not yet fixed and allowed by the Bankruptcy Court prior to or on the Effective Date.

1.62 ***ERISA*** means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

1.63 ***Estates*** means, as to each Debtor, the estates created upon the Petition Date pursuant to § 541.

1.64 ***Executory Agreement*** means any executory contract or unexpired lease subject to § 365, excluding (a) the Debtors' collective bargaining agreements, and (b) any executory contract or unexpired lease entered into after the Petition Date and approved by an order of the Bankruptcy Court.

1.65 ***Foundations*** means collectively the following Debtor nonprofit public benefit corporations that are responsible for fundraising and grant-making programs for each of their respective Debtor hospitals: O'Connor Hospital Foundation, Saint Louise Regional Hospital Foundation, St. Francis Medical Center of Lynwood Foundation, St. Vincent Foundation, and Seton Medical Center Foundation.

1.66 ***Final DIP Order*** means the *Final Order (I) Authorizing Postpetition Financing, (II) Authorizing Use of Cash Collateral, (III) Granting Liens and Providing Superpriority Administrative Expense Status, (IV) Granting Adequate Protection, (V) Modifying Automatic Stay, and (VI) Granting Related Relief* [Docket No. 409] entered by the Bankruptcy Court on October 5, 2018.

1.67 ***Final Order*** means an order or judgment, the operation or effect of which has not been reversed, stayed, modified, or amended, is in full force and effect, and as to which order or

judgment (or any reversal, stay, modification, or amendment thereof) (a) the time to appeal, seek *certiorari*, or request reargument, further review, or rehearing has expired and no appeal, petition for *certiorari,* request for reargument or further review, or rehearing has been timely filed, or (b) any appeal that has been or may be taken, or any petition for *certiorari* or request for reargument or further review or rehearing that has been or may be filed, has been resolved by the highest court to which the order or judgment was appealed, from which *certiorari* was sought, or to which the request was made, and no further appeal, petition for *certiorari*, request for reargument, or further review or rehearing has been or can be taken or granted; provided, however, that the possibility that a motion under Rule 60 of the Federal Rules of Civil Procedure, or any analogous rule under the Bankruptcy Rules, may be filed relating to such order shall not prevent such order from being a Final Order; provided, further, that the Debtors or Liquidating Trustee, as applicable, reserve the right to waive any appeal period for an order or judgment to become a Final Order.

1.68 ***First Priority Trust Beneficial Interests*** means the first priority Trust Beneficial Interest in the Plan Fund provided to the Holders of the Secured 2005 Revenue Bonds Claims which shall entitle such Holders to receive payment on the 2005 Revenue Bonds Diminution Claim until fully satisfied and before any payment on account of Second Priority Trust Beneficial Interests held by Holders of Allowed General Unsecured Claims.

1.69 ***General Unsecured Claim*** means (i) any unsecured claim that is not an Insured Claim, 2016 Data Breach Claim, or Subordinated General Unsecured Claim, (ii) any Claim for damages resulting from or based on the Debtors' rejection of an Executory Agreement, or (iii) any Claim that is determined by the Bankruptcy Court to be a prepetition general unsecured claim that is not entitled to priority or subject to subordination pursuant to this Plan.

1.70 ***Governmental Unit*** has the definition set forth in § 101(27).

1.71 ***Holder*** means a holder of a Claim against, or Interest in, the Debtors.

1.72 ***Holdings*** means Verity Holdings, LLC, as debtor and debtor in possession.

1.73 ***Hospital Licenses*** means licenses and permits issued by the CDPH and the California State Board of Pharmacy.

1.74 ***Hospital Premises*** means all locations where SFMC and Seton provide hospital services, including their primary locations at (i) 3630 East Imperial Highway, Lynwood, California 90262; (ii) 1900 Sullivan Avenue, Daly City, California 94015; (iii) 600 Marine Boulevard, Moss Beach, California 94038, respectively; and such other locations where SFMC and Seton provide hospital services**.**

1.75 ***Hospital Purchased Assets*** means the assets purchased by Prime and AHMC pursuant to the SFMC Asset Purchase Agreement and Seton Asset Purchase Agreement, respectively. For the avoidance of doubt, the Hospital Purchased Assets relate only to the Hospitals subject to the SFMC Sale and Seton Sale.

1.76 ***Hospitals*** means the hospitals and related facilities operated by SFMC and Seton subject to the SFMC Sale and Seton Sale.

1.77 ***Impaired*** means, with respect to a Class of Claims, that such Class is "impaired" within the meaning of § 1124.

1.78 ***Indenture Trustees*** means, collectively, the Master Trustee, the 2005 Revenue Bonds Trustee, the 2015 Notes Trustee and the 2017 Notes Trustee.

1.79 ***Indemnification Claim*** means any Claim for indemnification, subrogation, contribution, or reimbursement for all liabilities, loss, damages, costs and expenses of whatever kind, including attorneys' fees.

1.80 ***Initial Secured 2005 Revenue Bonds Claims Payment*** means the Cash on hand of the Debtors as of the Effective Date, net of the Cash (i) necessary to satisfy all Unclassified Claims and Class 1A Claims that are Allowed on or prior to the Effective Date, (ii) necessary to satisfy all Allowed Claims payable on the Effective Date to Classes 2, 3, 5, 6 and 7, and (iii) reserved under the Liquidating Trust Agreement, but in no event shall such amount be less than $98,200,000.00.

1.81 ***Insurance Policy*** means any insurance policy maintained by or for the benefit of the Debtors, regardless of whether such Insurance Policy is set forth in a schedule to the Plan Supplement.

1.82 ***Insured Claims*** means a Claim against any of the Debtors, their respective Estates, Assets or properties arising from any incident or occurrence that is covered by an applicable and available Insurance Policy.

1.83 ***Insured Deficiency Claim*** has the definition set forth in Section 4.10 hereof.

1.84 ***Insurer*** means any entity that issued an Insurance Policy, including any successors.

1.85 ***Intercompany Claims*** means any Claims held by a Debtor or a Non-Debtor Affiliate against a Debtor or Non-Debtor Affiliate, including, without limitation, any Indemnification Claim between and/or among the Debtors.

1.86 ***Intercreditor Agreement*** means the Second Amended and Restated Intercreditor Agreement, dated as of December 1, 2017, by and among VHS, on behalf of itself, and each Obligated Group Member, the 2015 Notes Trustee, the 2017 Notes Trustee and the Master Trustee.

1.87 ***Interests*** means any ownership interest in any of the Debtors, including but not limited to, membership interests or other entitlement to participate in the organizational affairs of a nonprofit entity organized under the laws of the State of California or equity interests in any for-profit corporation, partnership or limited liability company organized under the laws of any jurisdiction, including common stock, preferred stock, stock options and restricted stock awards.

1.88 ***Interim Agreements*** means, collectively, the Seton Interim Management Agreement, the Seton Interim Leaseback Agreement, the SFMC Interim Management Agreement, and the SFMC Interim Leaseback Agreement.

1.89 ***Interim Leaseback Agreements*** means, collectively, the Seton Interim Leaseback Agreement and the SFMC Interim Leaseback Agreement.

Case 2:18-bk-20151-ER Doc 5469-1 Filed 08/12/22 Entered 08/12/22 12:56:50 Desc
Desc Exhibit A (Verity Bankruptcy Plan) Page 18 of 80

1.90 ***Interim Management Agreements*** means, collectively, the Seton Interim Management Agreement and the SFMC Interim Management Agreement.

1.91 ***IRC*** means the Internal Revenue Code of 1986, as amended, and any applicable regulations (including temporary and proposed regulations) promulgated thereunder by the United States Treasury Department.

1.92 ***KCC*** means Kurtzman Carson Consultants LLC.

1.93 ***Lead Case*** means *In re Verity Health System of California, Inc.*, Lead Case No. 2:18-bk-20151-ER, under which the Chapter 11 Cases are jointly administered, pursuant to Bankruptcy Rule 1015(b), and the order entered by the Bankruptcy Court granting joint administration [Docket No. 17].

1.94 ***Liquidating Trust*** means the liquidating trust created pursuant to Section 6 herein.

1.95 ***Liquidating Trust Administration Accounts*** means one or more deposit accounts to be established pursuant to Section 7.8 of the Plan and maintained by the Liquidating Trustee to pay any and all reasonable costs and expenses incurred in implementing the terms of the Plan, as set forth in the Liquidating Trust Agreement.

1.96 ***Liquidating Trust Agreement*** means the Liquidating Trust Agreement, to be dated on or prior to the Effective Date, between the Debtors and the Liquidating Trustee, governing the disposition of the Liquidating Trust Assets, the distribution of the proceeds thereof in accordance with the Plan, and setting forth the duties and obligations of the Liquidating Trustee.

1.97 ***Liquidating Trust Assets*** means any and all Assets of the Estates (other than the Operating Assets, the Hospital Purchased Assets, the rights under the Interim Agreements and any claim, litigation or Cause of Action compromised as part of a Creditor Settlement Agreement) of every kind and character, wherever located, whether real or personal, tangible or intangible, transferred to the Liquidating Trust pursuant to the Plan and the Liquidating Trust Agreement, including, without limitation, to the extent not otherwise excluded by this definition:

(a) all Remaining Cash;

(b) all Causes of Action and the proceeds from the prosecution and/or settlement thereof;

(c) all rights, claims and/or assets under any and all contracts, agreements, and licenses (whether or not executory contracts, and whether or not rejected or assumed) of the Debtors, including all rights and/or assets retained by any of the Debtors, as the sellers under their respective asset sale agreements with third-party purchasers approved by the Bankruptcy Court prior to the Effective Date, including without limitation, Quality Assurance Payments retained by the Debtors, the accounts receivable arising out of the rendition of services or the sale of products in the ordinary course of business by such Debtors prior to the closing date of their respective sales and all other rights of the Debtors, as sellers, under such asset sale agreements;

(d) any proceeds of the foregoing; and

(e) all files, books and records relating to the Debtors' businesses or the administration of the Plan other than those required to be maintained by the Post-Effective Date Debtors for the administration of the Operating Assets.

1.98 ***Liquidating Trust Reserves*** means one or more accounts or reserves of Cash established by the Liquidating Trustee in accordance with Section 7.9.

1.99 ***Liquidating Trustee*** means such person selected pursuant to Section 6.5 of the Plan or any successor or replacement officer appointed under the terms of the Plan.

1.100 ***Local Bankruptcy Rules*** means the Local Rules of the United States Bankruptcy Court of the Central District of California, as amended from time to time.

1.101 ***Marillac*** means ***Marillac Insurance Company, LTD.***, the wholly-owned subsidiary of VHS, incorporated in the Cayman Islands on December 9, 2003.

1.102 ***Master Trustee*** means UMB Bank, N.A., as trustee for Obligations issued under that certain Master Indenture of Trust, dated as of December 1, 2001, as amended and supplemented, among the Daughters of Charity Health System, as predecessor in interest to VHS.

1.103 ***Medi-Cal*** means the program administered by the State of California for medical assistance under title XIX of the Social Security Act.

1.104 ***Medicare*** means the federal health insurance program administered under title XVIII of the Social Security Act.

1.105 ***Mechanics Lien Claims*** means all Allowed Claims arising under California Civil Code §§ 8400, *et seq*., with respect to any real property or personal property of a Debtor subject to a lien provided by such law.

1.106 ***MOB I Loan Agreement*** means that certain Term Loan Agreement, dated October 3, 2017, between Holdings and Verity MOB Financing LLC, in the amount of $ 46,363,096, and secured by those certain Los Angeles and San Mateo Deeds of Trust, each dated October 3, 2017, and the other security documents entered into in connection therewith.

1.107 ***MOB II Loan Agreements*** mean those certain Term Loan Agreements, dated June 1, 2018 and July 26, 2018, each between Holdings and Verity MOB Financing II LLC, in the amount of $20,000,000, and secured by those certain related Los Angeles, San Mateo, and Santa Clara Deeds of Trust, dated June 1, 2018, as thereafter modified, and the Los Angeles Deed of Trust, dated July 26, 2018, and the other security documents entered into in connection therewith.

1.108 ***Non-Debtor Affiliates*** means the following affiliates of the Debtors that did not file a Chapter 11 Case: DePaul - San Jose ASC, Marillac, O'Connor Health Center I, Sports Medical Management, Inc., St. Vincent De Paul Ethics Corporation, VHoldings, Robert F. Kennedy Medical Center, and Robert F. Kennedy Medical Center Foundation.

1.109 ***Nonprofit Laws*** means any and all federal, state, local and other laws and governmental regulations applicable to nonprofit corporations, including without limitation, any administrative and judicial interpretations thereof (as applicable).

1.110 ***Nonprofit Status*** means status as a nonprofit corporation under applicable Nonprofit Laws.

1.111 ***Obligated Group Member*** means each of the following Debtors: (i) VHS, (ii) O'Connor Hospital, (iii) Saint Louise Regional Hospital, (iv) Seton, (v) SFMC, and (vi) SVMC.

1.112 ***Obligations*** means those certain undertakings by Obligated Group Members arising from those certain Loan Agreements, dated December 1, 2001 and dated December 1, 2005, between CSCDA and the Daughters of Charity Health System as predecessor in interest to VHS, as amended and supplemented by those Loan Agreements dated December 1, 2015, and December 1, 2017, between CPFA and VHS.

1.113 ***Operate*** (and any such variations, such as "Operation") means to operate, oversee, manage, administer, coordinate, control, supervise and/or direct the business and operations of any and/or all of the Operating Assets, whether in the ordinary course of business or otherwise, and including undertaking or pursuing strategies, activities, or actions with the intent of furthering the objectives of, and otherwise to effectuate the Plan as contemplated by the provisions hereof, including any strategies, activities or actions aimed at retaining, renewing, amending, extending or Transferring any of the Operating Assets.

1.114 ***Operating Account*** means one or more deposit accounts of Cash established and/or maintained by the Liquidating Trustee as set forth in Section 7.6.

1.115 ***Operating Assets*** means, collectively,

(a) the Hospitals;

(b) the Hospital Purchased Assets; and

(c) the Post-Effective Date Debtors' right to Quality Assurance Payments.

1.116 ***Operating Budget*** means the budget (as the same may be amended or modified from time to time) setting forth the projected costs and expenses associated with the Operating Assets (including without limitation, the cost of Operating the Operating Assets).

1.117 ***Ordinary Course Professionals Order*** means the order [Docket No. 693] entered by the Bankruptcy Court granting the Debtors' motion to retain and compensate professionals utilized by the Debtors in the ordinary course of business [Docket No. 364].

1.118 ***Ordinary Course Professionals*** means the professionals retained by the Debtors in the ordinary course of their business operations, pursuant to the Ordinary Course Professionals Order.

1.119 ***Patient Care Ombudsman*** means Dr. Jacob Nathan Rubin, MD, FACC, appointed by the U.S. Trustee to serve as the patient care ombudsman in these Chapter 11 Cases, pursuant to § 333(a), in accordance with the order [Docket No. 430] entered by the Bankruptcy Court on October 9, 2018.

1.120 ***PBGC*** means the Pension Benefit Guaranty Corporation, a wholly owned United States corporation, and agency of the United States, that administers the defined benefit pension plan termination program under Title IV of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1301-1461 (2018).

1.121 ***PBGC Claims*** means the Claims that the PBGC has asserted, or is deemed to have asserted, against the Debtors in relation to Verity Health System Retirement Plan A and Verity Health System Retirement Plan B, including on account of alleged unfunded benefit liabilities, minimum funding contributions, fixed and variable rate premiums, and termination premiums, which are identified as (i) the Amended Proofs of Claim filed by PBGC in the Lead Case, denominated as Proofs of Claim No. 7754, 7759, 7760, 7761, 7762, and 7763, and (ii) deemed to have been filed in each of the Chapter 11 Cases identified in such Proofs of Claim, pursuant to that certain stipulation [Docket No. 1772] approved by order of the Bankruptcy Court [Docket No. 1782].

1.122 ***PBGC Settlement*** means that certain Creditor Settlement Agreement described in Section 7.1(b).

1.123 ***Person*** means an individual, partnership, corporation, limited liability company, business trust, joint stock company, trust, unincorporated association, joint venture, governmental authority, Governmental Unit or other entity of whatever nature.

1.124 ***Petition Date*** means August 31, 2018, which is the date that each Debtor filed a voluntary chapter 11 petition.

1.125 ***Pharmacy Assets*** means the portions of the Hospital Purchased Assets constituting drugs, dangerous devices, pharmacy systems, or other pharmacy assets, which will be purchased by and transferred to Prime and AHMC, respectively, on the dates Prime and AHMC obtain their required licenses, in accordance with the SFMC Asset Purchase Agreement and the Seton Asset Purchase Agreement.

1.126 ***Plan*** means this plan of liquidation proposed by the Plan Proponents, including the Plan Supplement and the exhibits hereto and thereto, as the same may be amended, modified or supplemented from time to time in accordance with the provisions of the Bankruptcy Code and its terms.

1.127 ***Plan Fund*** means one or more accounts or reserves of Cash established by the Liquidating Trustee in accordance with Section 7.10 hereof for the payment of, on or after the Effective Date, (i) the 2005 Revenue Bonds Diminution Claim, and (ii) Allowed General Unsecured Claims.

1.128 ***Plan Proponents*** means the Debtors, the Master Trustee, the 2005 Revenue Bonds Trustee, the 2015 Notes Trustee, the 2017 Notes Trustee, Verity MOB Financing LLC, Verity MOB Financing II, LLC, and the Committee.

1.129 ***Plan Settlement*** means that certain Creditor Settlement Agreement described in Section 7.1(a).

1.130 ***Plan Supplement*** means a supplemental appendix to this Plan, as may be amended from time to time on or prior to the Effective Date, which will contain the following items:

(a) the Schedule of Assumed Contracts;

(b) the schedule of Insurance Policies;

(c) the identity of the directors serving on the Post-Effective Date Board of Directors;

(d) the Transition Services Agreement;

(e) the initial Operating Budget;

(f) the identity of the initial Liquidating Trustee;

(g) the identity of the members of the Post-Effective Date Committee;

(h) the form of Liquidating Trust Agreement; and

(i) the Creditor Settlement Agreements, if any,

of which items (a) through (e) shall be filed prior to the Effective Date, items (f) through (h) shall be filed no later than fourteen (14) days before the Ballot Deadline, and item (i) shall be filed seven (7) days prior to the Ballot Deadline, if not earlier, in each case, unless otherwise extended with the consent of the Plan Proponents. Each of the foregoing documents may be filed separately. The Plan Supplement shall be in substance and form acceptable to the Plan Proponents.

1.131 ***Post-Effective Date Board of Directors*** means the three (3) member board of directors for VHS that shall be formed on the Effective Date in accordance with Section 5.9 hereof, which shall also serve as the members of the subsidiary boards and any other boards required to be in existence.

1.132 ***Post-Effective Date Committee*** means a committee that shall be formed on the Effective Date in accordance with Section 7.11 hereof, consisting of (i) three (3) members designated by the Committee, and (ii) until the First Priority Beneficial Trust Interests are paid in full, the Master Trustee, as ex officio and non-voting member.

1.133 ***Post-Effective Date Debtors*** means, collectively, the Sale-Leaseback Debtors, SVMC, St. Vincent Dialysis, the SCC Debtors, and VHS, which shall exist solely for the limited duration and purposes set forth in the Plan.

1.134 ***Prepetition Secured Creditors*** means, collectively, the Master Trustee, the 2005 Revenue Bonds Trustee, the 2015 Notes Trustee, the 2017 Notes Trustee, Verity MOB Financing LLC, and Verity MOB Financing II, LLC.

1.135 ***Prime*** means Prime Healthcare Services, Inc., or its designee under the SFMC Asset Purchase Agreement.

1.136 ***Priority Benefit Plan Claims*** means Claims entitled to priority under § 507(a)(5).

1.137 ***Priority Non-Tax Claim*** means any Claim entitled to priority in payment as specified in § 507(a)(4), (5), (6), (7) or (9) other than Administrative Claims and Priority Tax Claims.

1.138 ***Priority Tax Claims*** means Claims of any Governmental Unit entitled to priority under § 507(a)(8) and 507(c).

1.139 ***Pro Rata Share*** means, as applicable, the proportion that (i) an Allowed Claim in a particular Class bears to the aggregate amount of all Claims in such Class, or (ii) an Allowed Claim in a particular Class bears to the aggregate amount of all Claims in such Class and all Claims in any other Classes entitled to share in the same recovery. Such ratios shall be calculated as if all Claims in the particular Class asserted against all Debtors are Allowed Claims as of the Effective Date, unless specifically provided otherwise in the Plan.

1.140 ***Professional*** means any Person (a) retained in the Chapter 11 Cases by Final Order, pursuant to §§ 327, 363, and 1103 or otherwise; or (b) awarded compensation and reimbursement by the Bankruptcy Court, pursuant to § 503(b)(4); provided, however, that Professional does not include any Ordinary Course Professional.

1.141 ***Professional Claim*** means an administrative claim of a Professional for compensation for services rendered or reimbursement of costs, expenses, or other charges and disbursements incurred relating to services rendered or expenses incurred after the Petition Date and prior to and including the Effective Date.

1.142 ***Proof of Claim*** means a proof of claim, or a request for payment of an Administrative Claim, filed in these Chapter 11 Cases.

1.143 ***Provider Agreements*** means (i) the Medicare Health Insurance Benefits Agreements between any of the Debtors and DHHS, and (ii) the Medi-Cal Provider Agreements between any of the Debtors and DHCS.

1.144 ***Quality Assurance Fees*** means the Hospital Quality Assurance Fee originally imposed by SB 239 (Chapter 657, Statutes of 2013) on certain general acute care hospitals by California state law in order to make supplemental and grant payments and increased capitation payments to hospitals up to the aggregate upper payment limit and made permanent by the passage of Proposition 52 in November 2016.

1.145 ***Quality Assurance Payments*** means the supplemental and grant payments and increased capitation payments, to be funded out of the Hospital Quality Assurance Fee, to certain

general acute care hospitals as contemplated by SB 239 (Chapter 657, Statutes of 2013) up to the aggregate upper payment limit and made permanent by the passage of Proposition 52 in November 2016.

1.146 ***Records Retention Order*** means one or more orders entered by the Bankruptcy Court related to the retention and/or destruction of records.

1.147 ***Released Party*** means, individually and collectively, the Estates, the Debtors, the Committee, the members of the Committee, the Indenture Trustees and their affiliates, and each current and/or former member, manager, officer, director, employee, counsel, advisor, professional, or agents of each of the foregoing who were employed or otherwise serving in such capacity before or after the Petition Date.

1.148 ***Remaining Cash*** means the actual sum of Cash that constitutes Liquidating Trust Assets after (i) the payment of Cash necessary to satisfy all Unclassified Claims and Class 1A Claims that are Allowed on or prior to the Effective Date, (ii) the payment of all Allowed Claims payable on the Effective Date as set forth in Classes 2, 3, 4, 5, 6, and 7, and (iii) the transfer into or maintenance of funds in the Operating Accounts for the Post Effective Date Debtors on the Effective Date in accordance with the Section 7.6.

1.149 ***Request for Payment*** means a request for payment of an Administrative Claim filed in these Chapter 11 Cases.

1.150 ***Sale-Leaseback Debtors*** means, collectively, SFMC and Seton.

1.151 ***Sale Order*** means any Final Order of the Court entered pursuant to a request of, or motion by, the Debtors for authority to sell assets of the Estates pursuant to § 363.

1.152 ***SCC*** means the County of Santa Clara, a political subdivision of the State of California.

1.153 ***SCC Debtors*** means Saint Louise Regional Hospital and O'Connor Hospital, collectively.

1.154 ***SCC Sale*** means the sale authorized by the order entered by the Bankruptcy Court on December 27, 2018 [Docket No. 1153].

1.155 ***Schedule of Assumed Contracts*** means the schedule listing the Executory Agreements to be assumed pursuant to the Plan.

1.156 ***Scheduled*** means, with respect to any Claim, the status, priority, and amount, if any, of such Claim as set forth in the Schedules.

1.157 ***Schedules*** means the schedules of assets and liabilities and the statements of financial affairs filed by the Debtors in the Chapter 11 Cases pursuant to § 521 and Bankruptcy Rule 1007, which incorporate by reference the global notes and statement of limitations, methodology, and disclaimer regarding the Debtors' schedules and statements, as such schedules

or statements have been or may be further modified, amended, or supplemented from time to time in accordance with Bankruptcy Rule 1009 or Final Orders of the Bankruptcy Court.

1.158 ***Second Priority Trust Beneficial Interests*** means the second priority Trust Beneficial Interests provided to the Holders of Allowed General Unsecured Claims in full and final satisfaction of such Holders' Allowed General Unsecured Claims, which Trust Beneficial Interests shall entitle such Holders, after payment in full to Holders of First Priority Trust Beneficial Interests held by the Holders of the 2005 Revenue Bonds Diminution Claim, to receive *pro rata* payment from all Funds in the Plan Fund until the Allowed General Unsecured Claims are fully satisfied.

1.159 ***Secured 2005 Revenue Bond Claims*** means all Allowed Secured Claims of the Master Trustee and the 2005 Revenue Bonds Trustee for, and on behalf of, the beneficial holders of Series 2005 A, G, and H Revenue Bonds issued by the CSCDA.

1.160 ***Secured 2015 Revenue Notes Claims*** means all Allowed Secured Claims of the Master Trustee and the 2015 Revenue Notes Trustee for, and on behalf of, the beneficial holders of the 2015 Revenue Notes issued by the CPFA.

1.161 ***Secured 2017 Revenue Notes Claims*** means all Allowed Secured Claims of the Master Trustee and the 2017 Notes Trustee for, and on behalf of, the beneficial holders of the 2017 Notes issued by the CPFA.

1.162 ***Secured Claim*** means a Claim that is (a) secured by a lien on any of the Assets, which lien is valid, perfected, and enforceable under applicable law or by reason of a Final Order, to the extent of the value of the claimant's interest in such Asset, or (b) entitled to setoff under § 553, to the extent of the amount subject to such setoff, as determined pursuant to § 506(a).

1.163 ***Secured Mechanics Lien Claims*** means all Allowed Secured Mechanics Lien Claims.

1.164 ***Secured MOB I Financing Claims*** means all Allowed Secured Claims of Verity MOB Financing LLC arising from the MOB I Loan Agreement.

1.165 ***Secured MOB II Financing Claims*** means all Allowed Secured Claims of Verity MOB Financing II LLC arising from the MOB II Loan Agreements.

1.166 ***Secured PACE Tax Financing Claims*** means those certain Agreements to Pay Assessment and Finance Improvements dated May 11, 2017 and May 18, 2017 under the CSCDA CaliforniaFirst Program, respectively the Clean Fund Agreement to Pay Assessment and Petros Agreement to Pay Assessment, each for the limited purpose of providing bond financing for certain renewable energy, energy efficiency, water efficiency and seismic improvements permanently affixed to real property owned by Seton Medical Center located in Daly City, California, the proceeds of which financings are being held as program funds for authorized improvements by Wilmington Trust N.A. as indenture trustee under two bond indentures with CSCDA also dated May 11, 2017 and May 18, 2017.

1.167 ***Seton*** means Seton Medical Center and Seton Medical Center Coastside, collectively, as debtors and debtors-in-possession.

1.168 ***Seton Asset Purchase Agreement*** means that certain *Asset Purchase Agreement*, as may be amended from time to time, by and among VHS, Holdings, and Seton, on the one hand, and AHMC, on the other hand, as approved by the Bankruptcy Court pursuant to the Seton Sale Order.

1.169 ***Seton Closing Date*** means the date that the transactions contemplated by the Seton Asset Purchase Agreement are consummated.

1.170 ***Seton Interim Leaseback Agreement*** means that certain Sale Leaseback Agreement by and between Seton, on the one hand, and AHMC and its affiliates, on the other hand.

1.171 ***Seton Interim Management Agreement*** means that certain Interim Management Agreement by and between Seton, on the one hand, and AHMC and its affiliates, on the other hand.

1.172 ***Seton Sale*** means the sale authorized by the Seton Sale Order.

1.173 ***Seton Sale Order*** means that certain order [Docket No. 4634] approving the sale of certain assets of Seton, Holdings, and VHS to AHMC.

1.174 ***Settlement Released Parties*** means, collectively, the parties to the Plan Settlement and the PBGC Settlement who are the beneficiaries of a limited or general release under the Plan Settlement and the PBGC Settlement, respectively, solely to the extent of such limited or general release, as provided in this Plan.

1.175 ***SFMC*** means St. Francis Medical Center, as debtor and debtor in possession.

1.176 ***SFMC Asset Purchase Agreement*** means that certain *Asset Purchase Agreement*, as may be amended from time to time, by and among VHS, Holdings, and SFMC, on the one hand, and Prime, on the other hand, as approved by the Bankruptcy Court pursuant to the SFMC Sale Order.

1.177 ***SFMC Closing Date*** means the date that the transactions contemplated by the SFMC Asset Purchase Agreement are consummated.

1.178 ***SFMC Interim Leaseback Agreement*** means that certain Sale Leaseback Agreement by and between SFMC, on the one hand, and Prime and its affiliates, on the other hand.

1.179 ***SFMC Interim Management Agreement*** means that certain Interim Management Agreement by and between SFMC, on the one hand, and Prime and its affiliates, on the other hand.

1.180 ***SFMC Sale*** means the sale authorized by the SFMC Sale Order.

1.181 ***SFMC Sale Order*** means that certain order [Docket No. 4511] approving the sale of certain assets of SFMC, Holdings, and VHS to Prime.

1.182 ***SGM*** means Strategic Global Management, Inc.

1.183 ***SGM Asset Purchase Agreement*** means that certain *Asset Purchase Agreement*, dated January 8, 2019, as amended from time to time, by and among VHS, Holdings, SFMC, SVMC, St. Vincent Dialysis, and Seton, on the one hand, and SGM, on the other hand, as approved by the Bankruptcy Court, in connection with the SGM Sale [Docket No. 2305-1].

1.184 ***SGM Claims*** means all claims held by the Estates against SGM, its affiliates, and any other Person related thereto, including those related to the SGM Asset Purchase Agreement and the SGM Sale, including, but not limited to, (i) those claims asserted by the Debtors in *Verity Health System of California, Inc., et al. v. Strategic Global Management, Inc., et al. (In re Verity Health System of California, Inc.)*, Case No. 2:20-cv-00613-DSF, currently pending before the District Court, (ii) the consolidated appeals related to the SGM Asset Purchase Agreement and the SGM Sale captioned *Strategic Global Management, Inc. v. Verity Health System of California, Inc. (In re Verity Health System of California, Inc.*, Consolidated Case No. 2:19-cv-10352-DSF, and currently pending before the District Court (the "***SGM Action***"), and (iii) any other claims which may be asserted against any Person by, among other parties, the Debtors, the Liquidating Trustee, the Committee, or any other Estate representative, arising from or related to the SGM Asset Purchase Agreement, the SGM Sale, or SGM's participation in the Bankruptcy Cases.

1.185 ***SGM Sale*** means the sale authorized by the *Order (A) Authorizing the Sale of Certain of the Debtors' Assets to Strategic Global Management, Inc. Free and Clear of Liens, Claims, Encumbrances, and Other Interests; (B) Approving the Assumption and Assignment of an Unexpired Lease Relating Thereto; and (C) Granting Related Relief*, entered by the Bankruptcy Court on May 2, 2019 [Docket No. 2306].

1.186 ***Section 503(b)(9) Claims*** means Allowed Claims pursuant to § 503(b)(9).

1.187 ***St. Vincent Dialysis*** means St. Vincent Dialysis Center, Inc., as debtor and debtor in possession.

1.188 ***Statutory Fees*** means the fees payable pursuant to section 1930 of title 28 of the United States Code that were incurred in connection with these Chapter 11 Cases.

1.189 ***Subordinated General Unsecured Claims*** means Allowed Claims that have been found to be subject to subordination pursuant to § 510 (b) or (c) pursuant to a Final Order.

1.190 ***SVMC*** means St. Vincent Medical Center, as debtor and debtor in possession.

1.191 ***Tax Rate*** means, with respect to the 2005 Revenue Bonds, the rate of interest utilized to calculate any "Taxable Rate Adjustment," as that term is defined in the 2005 Revenue Bonds Indentures or the 2005 Revenue Bonds Obligated Bonds.

1.192 ***Transfer*** (and any variations such as "Transferring") means to, directly or indirectly, sell, convey, assign, pledge, encumber, hypothecate, gift, contribute, subject to a joint venture, partnership, or similar arrangement, abandon, convey, or transfer or otherwise dispose of, either voluntarily or involuntarily, any Asset or enter into any contract for any Asset that will effectuate the foregoing whether or not the foregoing is subject to approvals or conditions.

1.193 ***Transition Services Agreements*** or ***TSAs*** means those certain transition services agreements entered into by and between (i) Prime, VHS, and the Liquidating Trust, and (ii) AHMC, VHS, and the Liquidating Trust, each relating to (a) the services, information systems, and vendor arrangements (if any) to be provided by VHS to Prime and AHMC, and (b) the services, personnel, information systems, and vendor arrangements (if any) to be provided by Prime (or an affiliate) and AHMC (or an affiliate) to VHS and/or the Liquidating Trust; provided, however, that the services, personnel, and intellectual property utilized under the Interim Agreements shall terminate pursuant to the terms of the Interim Agreements.

1.194 ***Trust Beneficial Interests*** mean, collectively, (i) the interests in the Liquidating Trust of the Holders of Allowed Claims in Class 4 and their concomitant entitlement to distributions to be made by the Liquidating Trust on account of the 2005 Revenue Bonds Diminution Claim as set forth in Sections 8, 9, and 10, and (ii) the pro rata interests in the Liquidating Trust of the Holders of Allowed Claims in Class 8 and their concomitant entitlement to distributions to be made by the Liquidating Trust on account of Allowed General Unsecured Claims as set forth in Sections 8, 9, and 10. The Trust Beneficial Interests shall be evidenced as set forth in Section 9.4 and shall not be transferable, except to the limited extent provided in Section 9.6 and related provisions of the Liquidating Trust Agreement.

1.195 ***Trust Beneficiaries*** means the holders of Trust Beneficial Interests, as of any point in time.

1.196 ***Unclassified Claims*** means, collectively, Administrative Claims, Professional Claims, Statutory Fees, and Priority Tax Claims.

1.197 ***Unimpaired Claim*** means a Claim that is not impaired because the Plan leaves unaltered the legal, equitable, and contractual rights to which such Claim entitles the Holder of such Claim, as set forth in § 1124(1).

1.198 ***U.S. Trustee*** means the Office of the United States Trustee for the Central District of California.

1.199 ***VBS*** means Verity Business Services, a nonprofit public benefit corporation, as debtor and debtor in possession.

1.200 ***VHoldings*** means VHoldings MOB, LLC, a Non-Debtor.

1.201 ***VHS*** means Verity Health System of California, Inc., as debtor and debtor in possession.

1.202 ***VMF*** means Verity Medical Foundation, as debtor and debtor in possession.

B. Interpretation and Rules of Construction.

Unless otherwise specified, all Section or exhibit references in the Plan are to the respective Section in, or exhibit to, the Plan, as the same may be amended, waived, or modified from time to time. The words "herein," "hereof," "hereto," "hereunder," and other words of similar import refer to the Plan as a whole and not to any particular Section, subsection, or clause contained therein.

The headings in the Plan are for convenience of reference only and shall not limit or otherwise affect the provisions hereof. For purposes herein: (1) in the appropriate context, each term, whether stated in the singular or the plural, shall include both the singular and the plural, and pronouns stated in the masculine, feminine, or neuter gender shall include the masculine, feminine, and the neuter gender; (2) any reference herein to a contract, lease, instrument, release, indenture, or other agreement or document being in a particular form or on particular terms and conditions means that the referenced document shall be substantially in that form or substantially on those terms and conditions; (3) unless otherwise specified, all references herein to "Sections" are references to Sections hereof or hereto; (4) the rules of construction set forth in § 102 shall apply; and (5) any term used in capitalized form herein that is not otherwise defined, but that is used in the Bankruptcy Code or the Bankruptcy Rules, shall have the meaning assigned to that term in the Bankruptcy Code or the Bankruptcy Rules, as the case may be.

C. Controlling Document.

The Plan (without reference to the Plan Supplement) shall govern and control in the event of an inconsistency between the terms and provisions in the Plan (without reference to the Plan Supplement) and the terms and provisions in the Disclosure Statement, the Plan Supplement, any other instrument or document created or executed pursuant to the Plan, or any order (other than the Confirmation Order) referenced in the Plan (or any exhibits, schedules, appendices, supplements or amendments to any of the foregoing); provided that, notwithstanding anything herein to the contrary, the Confirmation Order shall govern and control in all respects in the event of a conflict between the Confirmation Order and any provision of the Plan or the Plan Supplement.

SECTION 2. ADMINISTRATIVE EXPENSE AND PRIORITY CLAIMS.

In accordance with § 1123(a)(1), the following Claims are not classified and are excluded from the Classes set forth in Section 3 hereof and shall receive the treatment discussed below:

2.1 ***Administrative Claims.*** Except to the extent that the Debtors (or the Liquidating Trust) and the Holder of an Allowed Administrative Claim agree to less favorable treatment, a Holder of an Allowed Administrative Claim (other than a Professional Claim, which shall be subject to Section 2.2) shall receive, in full satisfaction, settlement, release, and discharge of, and in exchange for, such Administrative Claim, Cash equal to the unpaid portion of such Allowed Administrative Claim either (a) on the Effective Date, (b) if the Allowed Administrative Claim is based on liabilities incurred by the Debtors in the ordinary course of their businesses after the Petition Date, in the ordinary course of business in accordance with the terms and conditions of the particular transaction giving rise to such Allowed Administrative Claim, without any further action by the Holder of such Allowed Administrative Claim, (c) on such other date as agreed between the Debtors (or the Post-Effective Date Debtors) and such Holder of an Allowed Administrative Claim, or (d) to the extent the Allowed Administrative Claim had not yet been Allowed on the Effective Date, from the Administrative Claims Reserve pursuant to Sections 7.9(d) and 15.3 hereof.

2.2 ***Professional Claims.*** All Professionals seeking an award by the Bankruptcy Court of a Professional Claim (other than the Ordinary Course Professionals) shall file their respective final applications for allowance of compensation for services rendered and reimbursement of

expenses incurred by the date that is sixty (60) days after the Effective Date, and shall receive, in full satisfaction of such Claim, Cash in an amount equal to 100% of such Allowed Professional Claim promptly after entry of an order of the Bankruptcy Court allowing such Claim or upon such other terms as may be mutually agreed-upon between the Holder of such Professional Claim and the Debtors, which Cash shall be paid out of the Effective Date Professional Claim Reserve. Objections to any final applications covering Professional Claims must be filed and served on the Post-Effective Date Debtors, the Liquidating Trustee, and the requesting Professional no later than ninety (90) days after the Effective Date (unless otherwise agreed by the requesting Professional).

2.3 ***Statutory Fees.*** All fees required to be paid by 28 U.S.C. § 1930(a)(6) and any interest thereon ("***U.S. Trustee Fees***") shall be paid by the Liquidating Trustee in the ordinary course of business until the closing, dismissal or conversion of these Chapter 11 Cases to another chapter of the Bankruptcy Code. Any unpaid U.S. Trustee Fees that accrued before the Effective Date shall be paid no later than thirty (30) days after the Effective Date.

2.4 ***Priority Tax Claims.*** Except to the extent that a Holder of an Allowed Priority Tax Claim agrees to less favorable treatment, each Holder of an Allowed Priority Tax Claim shall receive, in full and final satisfaction of such Allowed Priority Tax Claim, at the option of the Plan Proponents or the Liquidating Trustee, as applicable: (a) Cash in an amount equal to such Allowed Priority Tax Claim on, or as soon thereafter as is reasonably practicable, the later of (i) the Effective Date, to the extent such Claim is an Allowed Priority Tax Claim on the Effective Date, and (ii) the first Business Day after the date that is thirty (30) calendar days after the date such Priority Tax Claim becomes an Allowed Priority Tax Claim; or (b) equal annual Cash payments in an aggregate amount equal to the amount of such Allowed Priority Tax Claim, together with interest at the applicable rate pursuant to § 511, over a period not exceeding five (5) years from and after the Petition Date; provided, however, the Debtors and Liquidating Trustee, as applicable, reserve the right to prepay all or a portion of any such amounts at any time under this option at the discretion of the Plan Proponents and the Liquidating Trustee.

SECTION 3. CLASSIFICATION OF CLAIMS

3.1 ***Classification in General***.

A Claim is placed in a particular Class for all purposes, including voting, confirmation, and distribution under the Plan and under §§ 1122 and 1123(a)(1); provided that a Claim is placed in a particular Class for the purpose of receiving distributions pursuant to the Plan only to the extent that such Claim is an Allowed Claim in that Class and such Allowed Claim has not been satisfied, released, or otherwise settled prior to the Effective Date.

3.2 ***Grouping of Debtors for Deemed Substantive Consolidation***.

Consistent with the deemed substantive consolidation of the Debtors, as set forth more fully in Section 7.1, the Plan groups the Debtors together for purposes of describing treatment under the Plan, confirmation of the Plan, and making distributions in accordance with the Plan with respect to Claims against and Interests in the Debtors under the Plan. Accordingly, pursuant to the Plan, the Assets of the Debtors and their Estates, and the Claims against and Interests in the Debtors, will be treated as if the Debtors and their Estates are substantively consolidated on the

Effective Date. Notwithstanding the foregoing, such groupings shall not affect any Debtor's status as a separate legal entity, change the organizational structure of the Debtors' business enterprise, constitute a change of control of any Debtor for any purpose, cause a merger or consolidation of any legal entities, or cause the transfer of any Assets. Except as otherwise provided by or permitted under the Plan, all Debtors shall continue to exist as separate legal entities after the Effective Date.

3.3 ***Summary of Classification***.

The following table designates the Classes of Claims against each of the Debtors and specifies which of those Classes are (a) Not Impaired by the Plan, (b) Impaired by the Plan, and (c) entitled to vote to accept or reject the Plan in accordance with § 1126. In accordance with § 1123(a)(1), Administrative Claims, Professional Claims, Statutory Fees, and Priority Tax Claims, have not been classified. All of the potential Classes for the Debtors are set forth herein. Certain of the Debtors may not have holders of Claims in a particular Class or Classes, and such Classes shall be treated as set forth in Section 3.5.

All Debtors			
Class	**Designation**	**Impairment**	**Entitled to Vote**
1A	Priority Non-Tax Claims	Not Impaired	No (deemed to accept)
1B	Secured PACE Tax Financing Claims	Not Impaired	No (deemed to accept)
2	Secured 2017 Revenue Notes Claims	Impaired	Yes
3	Secured 2015 Revenue Notes Claims	Impaired	Yes
4	Secured 2005 Revenue Bond Claims	Impaired	Yes
5	Secured MOB I Financing Claims	Impaired	Yes
6	Secured MOB II Financing Claims	Impaired	Yes
7	Secured Mechanics Lien Claims	Impaired	Yes
8	General Unsecured Claims	Impaired	Yes
9	Insured Claims	Impaired	Yes
10	2016 Data Breach Claims	Impaired	Yes
11	Subordinated General Unsecured Claims	Impaired	No (deemed to reject)
12	Interests	Impaired	No (deemed to reject)

3.4 ***Special Provision Governing Unimpaired Claims***.

Except as otherwise provided in the Plan, nothing under the Plan shall affect the rights of the Debtors or the Liquidating Trust with respect to Unimpaired Claims, including all legal and equitable defenses to, or setoffs or recoupments against, any such Unimpaired Claims.

3.5 ***Elimination of Vacant Classes***.

Any Class of Claims, as of the commencement of the Confirmation Hearing, that does not have at least one (1) Holder of a Claim in an amount greater than zero for voting purposes shall be considered vacant, deemed eliminated from the Plan for purposes of voting to accept or reject the Plan, and disregarded for purposes of determining whether the Plan satisfies § 1129(a)(8) with respect to that Class.

SECTION 4. TREATMENT OF CLAIMS

In full and final satisfaction of all of the Claims against the Debtors (except with respect to Unclassified Claims that are satisfied in accordance with Section 2 above), the Claims shall receive the treatment described below. Except to the extent expressly provided in this Section 4, the timing of distributions is addressed in Section 8.3 hereof.

4.1 ***Class 1A: Priority Non-Tax Claims***.

(a) *Classification*. Class 1A consists of Priority Non-Tax Claims.

(b) *Treatment*. Except to the extent that a Holder of an Priority Non-Tax Claim agrees to a less favorable treatment of such Claim, each such Holder shall receive payment in Cash in an amount equal to the amount of such Allowed Claim, payable on the later of the Effective Date and the date that is fourteen (14) Days after the date on which such Priority Non-Tax Claim becomes an Allowed Priority Non-Tax Claim, in each case, or as soon as reasonably practicable thereafter in accordance with the priority scheme set forth in the Bankruptcy Code.

(c) *Voting*. Class 1A is Unimpaired. Holders of Priority Non-Tax Claims are deemed to have accepted the Plan, pursuant to § 1126(f), and are not entitled to vote to accept or reject the Plan.

4.2 ***Class 1B: Secured PACE Tax Financing Claims***.

(a) *Classification.* Class 1B consists of the Secured PACE Financing Claims.

(b) *Treatment.* Each Allowed Secured PACE Tax Financing Claim shall be paid in accordance with the *Order Approving Stipulation Resolving California Statewide Communities Development Authority Lien Release Pursuant to the Proposed Sale of Certain of the Debtors' Assets Related to Seton Medical Center* [Docket No. 4613].

(c) *Voting*. Class 1B is Unimpaired. Holders of Secured PACE Tax Financing Claims are deemed to have accepted the Plan, pursuant to § 1126(f), and are not entitled to vote to accept or reject the Plan.

4.3 ***Class 2: Secured 2017 Revenue Notes Claims***.

(a) *Classification.* Class 2 consists of the Secured 2017 Revenue Notes Claims.

(b) *Treatment.* The Secured 2017 Revenue Notes Claims shall be paid in cash on the Effective Date by the Debtors to the 2017 Notes Trustee for distribution in accordance with the 2017 Revenue Notes Indentures in an amount equal to 100% of a single Allowed Claim in the aggregate amount of $42,000,000, plus (i) any accrued, but unpaid postpetition interest, if any, at the rate specified in the 2017 Revenue Note Indentures, excluding any interest at a default rate, any make whole premium, any applicable redemption or other premium, and (ii) any accrued but unpaid reasonable, necessary out-of-pocket fees and expenses of the 2017 Notes Trustee and the Master Trustee pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date, less any amounts held by the 2017 Notes Trustee in a (x) principal or revenue

account, (y) debt service or redemption reserve, or (z) an escrow or expense reserve account. No beneficial Holder of any Secured 2017 Revenue Notes Claims shall be entitled to receive any distribution pursuant to the Plan, except as may be remitted to such holder by the 2017 Notes Trustee in accordance with the 2017 Revenue Notes Indenture.

(c) *Subordination:* Following receipt of the distribution provided in Section 4.3(b), all rights held by 2017 Revenue Bond Trustee and/or the Master Trustee under the Intercreditor Agreement shall be deemed satisfied, waived or released by the treatment provided in the Plan Settlement and the Plan.

(d) *Voting*. Class 2 is Impaired. The beneficial Holders of Secured 2017 Revenue Notes Claims are entitled to vote to accept or reject the Plan.

4.4 ***Class 3: Secured 2015 Revenue Notes Claims***.

(a) *Classification.* Class 3 consists of the Secured 2015 Revenue Notes Claims.

(b) *Treatment.* The Secured 2015 Revenue Notes Claims shall be paid in cash on the Effective Date by the Debtors to the 2015 Notes Trustee for distribution in accordance with the 2015 Revenue Notes Indentures in an amount equal to 100% of a single Allowed Claim in the aggregate amount of $160,000,000, plus (i) accrued, but unpaid postpetition interest, if any, at the rate specified in the 2015 Revenue Note Indentures for each of 2015 Revenue Notes Series A, B, C and D, excluding any interest at a default rate, or any applicable redemption or other premium, and (ii) any accrued, but unpaid reasonable, necessary out-of-pocket fees and expenses of the 2015 Notes Trustee and the Master Trustee, pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date, less any amounts held by the 2015 Notes Trustee on account of the 2015 Revenue Notes in a (x) principal or revenue account, (y) debt service or redemption reserve, or (z) an escrow or expense reserve account. No beneficial Holder of any Secured 2015 Revenue Notes Claims shall be entitled to receive any distribution pursuant to the Plan, except as may be remitted to such holder by the 2015 Notes Trustee.

(c) *Subordination:* All rights held by 2015 Revenue Bond Trustee and/or the Master Trustee under the Intercreditor Agreement shall be deemed satisfied, waived or released by the treatment provided in the Plan Settlement and the Plan.

(d) *Voting*. Class 3 is Impaired, and the beneficial Holders of Secured 2015 Revenue Notes Claims are entitled to vote to accept or reject the Plan.

4.5 ***Class 4: Secured 2005 Revenue Bond Claims***.

(a) *Classification.* Class 4 consists of the Secured 2005 Revenue Bonds Claims.

(b) *Treatment.* The Secured 2005 Revenue Bonds Claims shall be treated as a single Allowed Claim in the aggregate amount of $259,445,000 plus (i) accrued, but unpaid postpetition interest, if any, at the rate specified in the 2005 Revenue Bond Indentures through and including the Effective Date, excluding any interest at the default rate or the Tax Rate, or any applicable redemption or other premium, and (ii) any accrued, but unpaid reasonable, necessary out-of-pocket fees and expenses of the 2005 Revenue Bonds Trustee and the Master Trustee

pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date. The 2005 Revenue Bonds Claims shall be paid and satisfied as follows: (i) an amount equal to the Initial Secured 2005 Revenue Bonds Claims Payment plus (a) accrued, but unpaid postpetition interest, if any, at the rate specified in the 2005 Revenue Bond Indentures through and including the Effective Date, excluding any interest at the default rate or the Tax Rate, or any applicable redemption or other premium, and (b) any accrued, but unpaid reasonable, necessary out-of-pocket fees and expenses of the 2005 Revenue Bonds Trustee and the Master Trustee pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date, shall be paid in cash by the Debtors to the 2005 Revenue Bond Trustee on the Effective Date. In addition, (x) any amounts held by the 2005 Revenue Bonds Trustee in a (1) principal or revenue account, (2) debt service or redemption reserve, or (3) an escrow or expense reserve account shall be applied against the Secured 2005 Revenue Bonds Claim, and (y) the 2005 Revenue Bonds Trustee shall become the sole Trust Beneficiary and holder of all of the First Priority Trust Beneficial Interests in the amount of the 2005 Revenue Bonds Diminution Claim, including interest accruing after the Effective Date at the non-default rate provided for in the 2005 Revenue Bond Indentures. The foregoing payments and distributions shall be in full and final satisfaction of the Secured 2005 Revenue Bonds Claims as a single Allowed Claim. Notwithstanding distribution of First Priority Trust Beneficial Interests on account of the 2005 Secured Revenue Bonds Diminution Claim, the 2005 Revenue Bonds Trustee or the Master Trustee shall be entitled to retain and apply Adequate Protection Payments received during the course of these Cases on or on behalf of the 2005 Secured Revenue Bonds in the manner provided by the relevant indenture. No beneficial Holder of any Secured Series A, G and H Revenue Bonds Claims shall be entitled to receive any distribution pursuant to the Plan, except as may be remitted to such Holder by the 2005 Revenue Bonds Trustee.

(c) *Subordination:* All rights held by 2005 Revenue Bond Trustee and/or the Master Trustee under the Intercreditor Agreement shall be deemed satisfied, waived or released by the treatment provided in the Plan Settlement and the Plan.

(d) *Voting*. Class 4 is Impaired. The beneficial Holders of the Secured 2005 Series 2005 A, G and H Revenue Bond Claims are entitled to vote to accept or reject the Plan.

4.6 ***Class 5: Secured MOB I Financing Claims***.

(a) *Classification.* Class 5 consists of the MOB I Financing Claims.

(b) *Treatment.* The Secured MOB I Financing Claims shall be paid in cash on the Effective Date by the Debtors in an amount equal to 100% of a single Allowed Claim in the aggregate amount of $46,363,095.90, plus (i) accrued but unpaid postpetition interest, if any, at the rate specified in the MOB I Loan Agreement, excluding any interest at the default rate, or make whole premium, and (ii) any accrued, but unpaid reasonable, necessary out-of-pocket fees and expenses of Verity MOB Financing LLC, pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date.

(c) *Voting*. Class 5 is Impaired. Holders of MOB I Financing Claims are entitled to vote to accept or reject the Plan.

4.7 ***Class 6: Secured MOB II Financing Claims***.

(a) *Classification*. Class 6 consists of the Secured MOB II Financing Claims.

(b) *Treatment*. The Secured MOB II Financing Claims shall be paid in cash on the Effective Date by the Debtors in an amount equal to 100% of a single Allowed Claim in the aggregate amount of $20,061,919.48, plus (i) accrued, but unpaid postpetition interest, if any, at the rate specified in the MOB II Loan Agreements, excluding any interest at the default rate, or make whole premium, and (ii) any accrued but unpaid reasonable, necessary out-of-pocket fees and expenses of Verity MOB Financing II LLC, pursuant to the Final DIP Order and Cash Collateral Orders through and including the Effective Date.

(c) *Voting*. Class 6 is Impaired. Holders of Secured MOB II Financing Claims are entitled to vote to accept or reject the Plan.

4.8 ***Class 7: Secured Mechanics Lien Claims***.

(a) *Classification*. Class 7 consists of the Secured Mechanics Lien Claims.

(b) *Treatment*. Each Allowed Secured Mechanics Lien Claim shall be paid in cash on the Effective Date by the Debtors in an amount equal to 100% of the principal balance of such Allowed Secured Mechanics Lien Claim.

(c) *Voting*. Class 7 is Impaired. Holders of Secured Mechanics Lien Claims are entitled to vote to accept or reject the Plan.

4.9 ***Class 8: General Unsecured Claims***.

(a) *Classification.* Class 8 consists of the General Unsecured Claims against all Debtors.

(b) *Treatment*. As soon as practicable after the Effective Date or as soon thereafter as the claim shall have become an Allowed Claim, each holder of an Allowed General Unsecured Claim shall receive a Second Priority Trust Beneficial Interest and become a Trust Beneficiary in full and final satisfaction of its Allowed Class 8 Claim, except to the extent that such Holder agrees (a) to a less favorable treatment of such Claim, or (b) such Claim has been paid before the Effective Date.

(c) *Voting*. Class 8 is Impaired. Holders of General Unsecured Claims are entitled to vote to accept or reject the Plan.

4.10 ***Class 9: Insured Claims.***

(a) *Classification*. Class 9 consists of Allowed Insured Claims.

(b) *Treatment.* Each Insured Claim shall be deemed objected to and disputed and shall be resolved in accordance with this Section, notwithstanding any other Plan provision.

Except to the extent that a Holder of an Insured Claim agrees to different treatment, or unless otherwise provided by an order of the Bankruptcy Court directing such Holder's participation in any alternative dispute resolution process, on the Effective Date, or as soon thereafter as is reasonably practicable, each Holder of an Insured Claim will have received or shall receive on account of its Insured Claim relief from the automatic stay under § 362 and the injunctions provided under this Plan for the sole and limited purpose of permitting such Holder to seek recovery, if any, as determined and Allowed by an order or judgment by a court of competent jurisdiction or under a settlement or compromise of such Holder's Insured Claim from the applicable and available Insurance Policies maintained by or for the benefit of any of the Debtors. A Holder's recovery of insurance proceeds under the applicable Insurance Policy(ies) shall be the sole and exclusive recovery on an Insured Claim, subject to recovery of an Insured Deficiency Claim, as described in the next paragraph. Any settlement of an Insured Claim within a self-insured retention or deductible must be approved by the Liquidating Trustee; provided, however, that the foregoing shall not apply to workers' compensation claims resolved by Old Republic Insurance Company under its applicable workers' compensation insurance policies.

In the event the applicable Insurer denies the tender of defense or there are no applicable or available insurance policies, or proceeds from applicable and available insurance policies have been exhausted or are otherwise insufficient to pay in full a Holder's recovery, if any, as determined by an order or judgment by a court of competent jurisdiction or under a settlement or compromise of such Holder's Insured Claim, on account of its Insured Claim, then such Holder shall be entitled to an Allowed Claim equal to the amount of the Allowed Insured Claim less the amount of available proceeds paid such Allowed Insured Claim from the applicable and available Insurance Policies (the "***Insured Deficiency Claim***"). Such Holders' Insured Deficiency Claim shall be treated as an Allowed General Unsecured Claim in Class 8 of the Plan and shall be entitled to receive its Pro Rata Share of the distributions from the Liquidating Trust Distributions as set forth in the Plan in the same manner as other Holders of Allowed General Unsecured Claims in Class 8 of the Plan. In no event shall any Holder of an Allowed Insured Deficiency Claim be entitled to receive more than one hundred percent (100%) of the Allowed Amount of their respective Allowed Insured Deficiency Claim.

Any amount of an Allowed Insurance Claim within a deductible or self-insured retention shall be paid by the applicable insurance, in accordance with the applicable Insurance Policy, to the Claim Holder and such Insurer shall have a General Unsecured Claim (or Secured Claim, if it holds collateral) for the amount of the deductible or retention paid, provided that it has timely filed an otherwise not objectionable proof of claim encompassing such amounts. For purposes of retentions and deductibles in any Insurance Policy, including, but not limited to, an Insurance Policy insuring officers, directors, consultants or others against claims based upon prepetition occurrences, the Confirmation Order shall constitute a finding that the Debtors are insolvent and unable to advance or indemnify Insured Claims, from Estate or Debtor Funds, for any loss, claim, damage, settlement or judgment of Debtors within the applicable retention or deductible amount. However, the foregoing sentence does not modify the Insurer's right to a claim described in the first sentence of this paragraph or limit reimbursement due Old Republic Insurance Company for deductibles from proceeds of other insurance. Notwithstanding any other provision of this Section, Old Republic Insurance Company shall be entitled to all accommodations that it requested in connection with renewal of Debtors' workers' compensation policy, as approved by order of the Bankruptcy Court [Docket No. 2803].

(c) *Voting*. Class 9 is Impaired. Holders of Insured Claims are entitled to vote to accept or reject the Plan. Unless otherwise ordered by the Bankruptcy Court, each Holder of a Class 9 Insured Claim shall have a $1.00 vote for each filed Insured Claim.

4.11 ***Class 10: 2016 Data Breach Claims***.

(a) *Classification.* Class 10 consists of Allowed 2016 Data Breach Claims.

(b) *Treatment.* Each holder of an Allowed 2016 Data Breach Claim shall receive access to credit monitoring services at the sole cost of the Debtors for a period of two (2) years following the Effective Date.

(c) *Voting*. Class 10 is Impaired. Holders of Allowed 2016 Data Breach Claims are entitled to vote to accept or reject the Plan.

4.12 ***Class 11: Subordinated General Unsecured Claims***.

(a) *Classification:* Class 11 Claims consists of Subordinated General Unsecured Claims.

(b) *Treatment:* Holders of Allowed Subordinated General Unsecured Claims shall not receive any recovery from the Debtors on or after the Effective Date.

(c) *Voting*. Class 11 is Impaired. Holders of Subordinated General Unsecured Claims are deemed to reject the Plan and are not entitled to vote.

4.13 ***Class 12: Interests***.

(a) *Classification*: Class 12 consists of Allowed Interests against any Debtor.

(b) *Treatment.* Holders of Allowed Interests shall not receive any recovery from the Debtors under the Plan.

(c) *Voting*. Class 12 is Impaired. The holders of Interests are deemed to reject the Plan and are not entitled to vote.

SECTION 5. POST-EFFECTIVE DATE GOVERNANCE

5.1 ***Dissolution of Certain Debtors.*** The following Debtors shall be dissolved, under applicable non-bankruptcy law on the Effective Date or shortly thereafter, as determined by the Liquidating Trustee, and each respective Debtor's interests and rights shall be vested, for all purposes in the Liquidating Trust, and all of the interests in such Debtors shall be cancelled and terminated without further order of the Bankruptcy Court: VBS; Holdings; De Paul Ventures; and De Paul - San Jose Dialysis.

5.2 ***Dissolution of Certain Non-Debtor Affiliates***. On the Effective Date, the following Non-Debtor Affiliates shall be dissolved, under applicable non-bankruptcy law: DePaul - San Jose

ASC; St. Vincent De Paul Ethics Corporation; VHoldings; Robert F. Kennedy Medical Center; Robert F. Kennedy Medical Center Foundation; and Sports Medical Management, Inc.

5.3 ***Dissolution of Sale-Leaseback Debtor Foundations.***

(a) Dissolution of St. Francis Medical Center of Lynwood Foundation. Until the SFMC Closing Date, St. Francis Medical Center of Lynwood Foundation shall continue to make distributions to SFMC in the ordinary course of business, with any properly donor-restricted gifts distributed in accordance with the terms and conditions of such restricted gift. After the SFMC Closing Date, the properly donor-restricted charitable assets of St. Francis Medical Center of Lynwood Foundation shall be transferred pursuant to approvals to be received from the Attorney General of California, pursuant to section 999.2(e) of title 11 of the California Code of Regulations and related statutes and regulations. Thereafter, St. Francis Medical Center of Lynwood Foundation shall be dissolved under applicable non-bankruptcy law.

(b) Dissolution of Seton Medical Center Foundation. Until the Seton Closing Date, Seton Medical Center Foundation shall continue to make distributions to Seton in the ordinary course of business, with any properly donor-restricted gifts distributed in accordance with the terms and conditions of such restricted gift. After the Seton Closing Date, the properly donor-restricted charitable assets of the Seton Medical Center Foundation shall be transferred pursuant to approvals to be received from the Attorney General of California, pursuant to section 999.2(e) of title 11 of the California Code of Regulations and related statutes and regulations. Thereafter, Seton Medical Center Foundation shall be dissolved under applicable non-bankruptcy law.

5.4 ***Dissolution of the SCC Debtor Foundations.*** On the Effective Date or shortly thereafter, the properly donor-restricted charitable assets of Saint Louise Regional Hospital Foundation and O'Connor Hospital Foundation shall be transferred pursuant to approvals to be received from the Attorney General of California, pursuant to section 999.2(e) of title 11 of the California Code of Regulations and related statutes and regulations. Thereafter, each respective Foundation shall be dissolved under applicable non-bankruptcy law.

5.5 ***Dissolution of St. Vincent Foundation.*** On the Effective Date or shortly thereafter, the properly donor-restricted charitable assets of St. Vincent Foundation shall be transferred pursuant to approvals to be received from the Attorney General of California, pursuant to section 999.2(e) of title 11 of the California Code of Regulations and related statutes and regulations. Thereafter, St. Vincent Foundation shall be dissolved under applicable non-bankruptcy law.

5.6 ***Dissolution of VMF.*** VMF shall be dissolved, under applicable non-bankruptcy law, as soon as practicable after completion of the claims process under VMF's capitation agreements.

5.7 ***Disposition of Marillac***. VHS, in its capacity as a Debtor and/or a Post-Effective Date Debtor, and/or the Liquidating Trustee shall take such action as reasonably necessary and advisable to effectuate the sale, disposition, or other administration of the issued and outstanding equity interests in, or assets of, Marillac. The net Cash proceeds of such sale, disposition, or other administration, if any, shall be used to pay Holders of Claims as set forth in this Plan or as otherwise agreed pursuant to a Creditor Settlement Agreement.

5.8 ***Continued Existence of Post-Effective Date Debtors After the Effective Date***.

(a) Continued Existence of Post-Effective Date Debtors. On and after the Effective Date, the Post-Effective Date Debtors shall continue in existence for the purposes set forth herein, and retain their Nonprofit Status to the same extent as such status existed immediately prior to the Petition Date. No party shall take any action to interfere with, alter, terminate or otherwise adversely affect the Nonprofit Status of the Post-Effective Date Debtors.

(b) Responsibilities of the Sale-Leaseback Debtors. The Sale-Leaseback Debtors shall continue in existence for the following limited purposes:

(i) to maintain their corporate existence and full rights as the licensees under the Hospital Licenses so Prime and AHMC may obtain their general acute care hospital licenses from the CDPH and their hospital pharmacy permits from the California State Board of Pharmacy pursuant to their respective Interim Management Agreements;

(ii) to retain statutory and regulatory authority and responsibility for the Hospitals and for oversight over Prime and AHMC, respectively;

(iii) to maintain a possessory interest in the Hospitals, and to lease from Prime and AHMC the Hospital Premises and the Hospital Purchased Assets, pursuant to the Interim Leaseback Agreements and to take such actions as appropriate, necessary, advisable or convenient to further the objectives of, and effectuate, the Interim Management Agreements as contemplated by the provisions of this Plan;

(iv) to maintain the Provider Agreements for Medi-Cal and Medicare, and participate in the Medi-Cal and Medicare programs, until the changes of ownership to Prime and AHMC, respectively, are approved, and collect or otherwise liquidate all amounts owing under the Provider Agreements until all payments due under such agreements have been received by the Post-Effective Date Debtors and, if appropriate, transferred to the Liquidating Trust;

(v) to process claims from providers under capitation agreements, if applicable;

(vi) in furtherance of implementation of the provisions of the Plan, to take any action necessary under applicable law that is consistent with the provisions of the Plan with respect to the Post-Effective Date Debtors and the Hospital Purchased Assets; and

(vii) to take such other actions as may be necessary or appropriate with respect to the affairs, businesses and/or operations of any of the Debtors which are not permitted to be undertaken by the Liquidating Trust under applicable law;

provided, however, that, notwithstanding the foregoing, Seton shall continue in existence solely for the limited purposes set forth in Section 5.8(b) hereof in the event that (i) the transfer of the Seton Pharmacy Assets, (ii) the expiration of the Seton Interim Leaseback Agreement, and (iii) the expiration of the Seton Interim Management Agreement all occur prior to the Effective Date.

(c) Responsibilities of SVMC and St. Vincent Dialysis. SVMC and St. Vincent Dialysis shall continue in existence for the following limited purposes:

(i) to maintain their corporate existence and full rights to receive any payments, including, but not limited to, payments related to Medi-Cal, Medicare, and the Quality Assurance Payments;

(ii) in furtherance of implementation of the provisions of the Plan, to take any action necessary under applicable law that is consistent with the provisions of the Plan; and

(iii) to take such other actions as may be necessary or appropriate with respect to the affairs, businesses and/or operations of any of SVMC and St. Vincent Dialysis which are not permitted to be undertaken by the Liquidating Trust under applicable law.

(d) Responsibilities of the SCC Debtors. The SCC Debtors shall continue in existence for the following limited purposes:

(i) to maintain their corporate existence and full rights to receive any payments, including, but not limited to, payments related to Medi-Cal, Medicare, and the Quality Assurance Payments;

(ii) in furtherance of implementation of the provisions of the Plan, to take any action necessary under applicable law that is consistent with the provisions of the Plan; and

(ii) to take such other actions as may be necessary or appropriate with respect to the affairs, businesses and/or operations of any of the SCC Debtors which are not permitted to be undertaken by the Liquidating Trust under applicable law.

(e) Responsibilities of VHS. VHS shall continue in existence through the expiration of the Interim Agreements and Transition Services Agreement, or as otherwise determined by the Liquidating Trustee, for the following limited purposes: (i) perform support services in accordance with the Interim Agreements and Transition Services Agreement and take other actions as required under the Interim Agreements and Transition Services Agreement; (ii) facilitate the payment of the Liquidating Trustee and its associated professionals; (iii) effectuate the expeditious sale of the issued and outstanding equity interests in Marillac or provide such other disposition that may be appropriate, to the extent such sale or other disposition is not effectuated prior to the Effective Date; and (iv) perform all actions required of the Debtors under any Executory Agreements set forth in the Schedule of Assumed Contracts.

(f) No Further Approvals Required. In performance of their duties hereunder, Post-Effective Date Debtors shall have the rights and powers of a debtor in possession under § 1107, and such other rights, powers, and duties necessary, appropriate, advisable or convenient to effectuate the provisions of the Plan. On and after the Effective Date, the Post-Effective Date Debtors shall not be required to obtain any approvals from the Bankruptcy Court, any court or Governmental Unit and/or provide any notices under the Nonprofit Laws to implement the terms of the Plan.

(g) Dissolution. The Liquidating Trustee will cause each Post-Effective Date Debtor to be dissolved for all purposes under applicable non-bankruptcy law, as follows:

(i) with respect to the Sale-Leaseback Debtors, after (x) the transfer of the Pharmacy Assets and the expiration of the Interim Agreements, (y) the filing of the final cost reports with CMS and DHCS, if the Sale-Leaseback Debtors are required to remain in existence to file such reports, and (z) after completion of the claims process under the capitation agreements, if required;

(ii) with respect to SVMC and St. Vincent Dialysis, after the receipt of all payments related to Medi-Cal and Medicare, including the Quality Assurance Payments;

(iii) with respect to the SCC Debtors, after the receipt of all payments related to Medi-Cal and Medicare, including the Quality Assurance Payments; and

(iv) with respect to VHS, after (x) the transfer of the Pharmacy Assets and the expiration of the Interim Agreements, and (y) performance of all actions required of the Debtors under any Executory Agreements under the Schedule of Assumed Contracts.

The Liquidating Trustee may dissolve a Post-Effective Date Debtor, earlier than as set forth above, if he or she determines that the continued existence of such Post-Effective Date Debtor is not necessary to satisfy the foregoing conditions. Such dissolution shall occur without the necessity for any other or further actions to be taken by or on behalf of the Post-Effective Debtors, or payment of any fees, charges, penalties or other amounts required by applicable non-bankruptcy law; provided, however, that the Liquidating Trustee may in its discretion file any certificates of cancellation as may be appropriate in connection with dissolution of the Post-Effective Date Debtors.

5.9 ***Post-Effective Date Board of Directors***.

(a) Post-Effective Date Board of Directors of VHS. On the Effective Date, the board members of VHS shall resign and the Post-Effective Date Board of Directors of VHS will be appointed. The members that make up the Post-Effective Date Board of Directors of VHS shall also serve and remain as the members of the subsidiary boards and any other boards required to be in existence.

(b) Duties. The Post-Effective Date Board of Directors shall (i) fulfill its duties and obligations under the bylaws and state and federal law, and (ii) oversee the Liquidating Trustee in his/her capacity as president of the Post-Effective Date Debtors consistent with the terms of this Plan.

(c) Resignation. Any member of the Post-Effective Date Board of Directors may resign at any time upon not less than thirty (30) days' written notice to the Liquidating Trustee and the Post-Effective Date Committee; provided, that, the Liquidating Trustee may waive such notice period.

(d) Replacement. Notwithstanding anything in the bylaws to the contrary, in the event that a director serving on the Post-Effective Date Board of Directors resigns or is duly removed for cause, or in the event of the death of any such director or other occurrence rendering such director incapacitated or unavailable for a period of thirty (30) consecutive days, a replacement director shall be designated by the remaining members of the Post-Effective Date Board of Directors of VHS in consultation with the Liquidating Trustee.

(e) Termination. The terms of the Post-Effective Date Board of Directors shall expire upon the date they are no longer required under state law as to each Debtor, as applicable.

(f) Limitation of Liability of the Post-Effective Date Board of Directors. The liability of the Post-Effective Date Board of Directors shall be limited to the maximum extent permitted by law, including any exculpations under the articles of incorporation or bylaws of the Post-Effective Date Debtors.

5.10 ***Document Preservation***. The Liquidating Trust shall comply the Document Retention Policy attached as Exhibit A to Docket No. 3355.

SECTION 6. THE LIQUIDATING TRUST

6.1 ***Creation***. On the Effective Date, the Liquidating Trust shall be created and all of the Liquidating Trust Assets shall be transferred to the Liquidating Trust, pursuant to the terms of the Liquidating Trust Agreement. Nothing in this Plan, including the implementation of the Liquidating Trust, or actions or inactions by the Liquidating Trustee after the Effective Date, shall alter, terminate, or otherwise adversely affect the Nonprofit Status of the Post-Effective Date Debtors; provided, further, that the transfer of Causes of Action to the Liquidating Trust shall not impair any parties' rights, defenses, claims, or counterclaims that have been or could be asserted unless otherwise settled.

6.2 ***Purposes of the Liquidating Trust.*** The primary purpose of the Liquidating Trust shall be the liquidation and distribution of its assets, in accordance with 26 C.F.R. § 301.7701-4(d). The primary functions of the Liquidating Trust are as follows: (i) to liquidate, sell, or dispose of the Trust Assets; (ii) to cause all net proceeds of the Trust Assets, including proceeds of Causes of Action on behalf of the Liquidating Trust, to be deposited into the Liquidating Trust; (iii) to initiate actions to resolve any remaining issues regarding the allowance and payment of Claims including, as necessary, initiation and/or participation in proceedings before the Court; (iv) to take such actions as are necessary or useful to maximize the value of the Liquidating Trust; (v) to effectuate the wind-down of the Debtors as set forth in the Plan; and (vi) to make the payments

and distributions to Holders of Allowed Claims, including Trust Beneficiaries, as required by the Plan.

6.3 ***The Liquidating Trust Agreement.*** The Liquidating Trust Agreement executed by the parties thereto shall be filed not less than fourteen (14) days prior to the Ballot Deadline, provided, that a copy of the Liquidating Trust Agreement in substantially final form shall be included in the Disclosure Statement. The Liquidating Trust Agreement, including the designation of the Liquidating Trustee thereunder, shall be approved by the Court, and the designated Liquidating Trustee shall accept their duties thereunder on or before the Confirmation Date. The Liquidating Trust Agreement shall, among other things, create the Liquidating Trust, identify the Liquidating Trustee, identify the compensation of the Liquidating Trustee, and specify the authorities and powers of the Liquidating Trustee and the Post-Effective Date Committee consistent with this Plan. The Liquidating Trust Agreement may only be amended, modified and/or supplemented by providing 5 business days written notice to the Plan Proponents, and if any of the Plan Proponents shall object to such amendment, modification and/or supplement in writing, subject to Bankruptcy Court approval, after notice and a hearing.

6.4 ***Operations of the Liquidating Trust.*** From and after the Effective Date, the Liquidating Trust may use and dispose of Liquidating Trust Assets, and take any of the actions consistent with this Plan and/or the Liquidating Trust Agreement without the approval of the Court and free of the restrictions of the Bankruptcy Code, the Bankruptcy Rules, and the Local Bankruptcy Rules, provided that the Liquidating Trust will be administered so that it qualifies as a liquidating trust under 26 C.F.R. § 301.7701-4(d). The actions of the Liquidating Trust and the Liquidating Trustee shall be governed by the provisions of the Liquidating Trust Agreement.

6.5 ***Liquidating Trustee***.

(a) Appointment. The Liquidating Trustee shall be selected by the Committee with the consent of the Master Trustee, such consent not to be unreasonably withheld. The Liquidating Trustee shall be deemed appointed on the Effective Date, without further motion, application, notice, hearing, or other order of the Bankruptcy Court. The appointment, duties, and powers of the Liquidating Trustee are as set forth in Article 3 of the Liquidating Trust Agreement. The Liquidating Trustee shall also serve as the president of each Post-Effective Date Debtor in accordance with the articles of incorporation or bylaws of the Post-Effective Date Debtors.

(b) Duties. After the Effective Date, without necessity of any further order of the Bankruptcy Court and/or any federal or state court, the Liquidating Trustee shall have the responsibilities set forth in (i) the Liquidating Trust Agreement, (ii) the articles of incorporation or bylaws of the Post-Effective Date Debtors, and (iii) this Plan, which include, but are not limited to, those set forth below:

(i) implement this Plan and administer the Liquidating Trust;

(ii) hold legal title to any and all rights of the Trust Beneficiaries in or arising from the Liquidating Trust Assets, including, but not limited to, collecting, receiving any and all money and other property belonging to the

Liquidating Trust and the right to vote any claim or interest in a case under the Bankruptcy Code and receive any distribution therein;

(iii) perform the duties, exercise the powers, and assert the rights of a trustee under §§ 704 and 1106, including, without limitation, commencing, prosecuting or settling Causes of Action, enforcing contracts, and asserting claims, defenses, offsets and privileges and shall be deemed substituted as plaintiff therein without need for any further order of the Bankruptcy Court and shall have all of the standing, rights, powers and obligations of the Debtors and the Non-Debtor Affiliates for all purposes with respect to the Liquidating Trust Assets;

(iv) be responsible for the following related to the Post-Effective Date Debtors:

(a) oversee the management and operations of the Hospital Purchased Assets pursuant to the Interim Agreements, including, without limitation, the administration of all obligations and claims, and the Transfer or other disposition of the Hospital Purchased Assets;

(b) oversee and implement the responsibilities and duties of the Sale-Leaseback Debtors;

(c) ensure compliance with the Interim Agreements;

(d) report to the respective board on a regular basis and provide such information and reports that may be reasonably requested by the Post-Effective Date Board of Directors;

(e) oversee SVMC's, St. Vincent Dialysis's, and the SCC Debtors' collection of Quality Assurance Payments and other accounts; and

(f) oversee and implement the responsibilities and duties of VHS, including, but not limited to, ensuring compliance with the Interim Agreements and the Transition Services Agreements;

(v) protect and enforce the rights to the Liquidating Trust Assets by any method deemed appropriate including, without limitation, by judicial proceedings or pursuant to any applicable bankruptcy, insolvency, moratorium or similar law and general principles of equity;

(vi) compromise, adjust, arbitrate, sue on or defend, pursue, prosecute, abandon, or otherwise deal with and settle, in accordance with the terms of the Liquidating Trust Agreement, the Causes of Action in favor of or against the Liquidating Trust as the Liquidating Trustee shall deem advisable;

(vii) avoid and recover transfers of the Debtors and Non-Debtor Affiliates' property as may be permitted by the Bankruptcy Code or applicable state law, including, without limitation, those identified in the Disclosure Statement;

(viii) determine and satisfy any and all liabilities created, incurred or assumed by the Liquidating Trust;

(ix) estimate, object to, defend against and otherwise administer Claims (except for Professional Claims, the 2005 Revenue Bonds Diminution Claim, and any Allowed Claims payable on or prior to the Effective Date) and Interests or requests for payment or allowance of an administrative expense;

(x) file, if necessary, any and all tax and information returns with respect to the Liquidating Trust, including the Liquidating Trust Reserves, and pay taxes properly payable by the Liquidating Trust, if any;

(xi) obtain insurance coverage with respect to the liabilities and obligations of the Liquidating Trustee under this Liquidating Trust Agreement (in the form of an errors and omissions policy or otherwise);

(xii) continue to ensure compliance with the terms of the Transition Services Agreements related to the SFMC Sale and the Seton Sale;

(xiii) serve as the president, or appoint an officer, of SVMC, St. Vincent Dialysis, and the SCC Debtors;

(xiv) report to the Post-Effective Date Committee;

(xv) enforce the terms of the Interim Agreements and the Transition Services Agreements;

(xvi) perform tasks necessary to effectuate termination of the Defined Contribution Plans, if any; and

(xvii) take any action required or permitted by the Plan.

(c) Oversight. The Liquidating Trustee shall keep the Master Trustee informed, from time to time, of the progress of the Liquating Trust in collecting and liquidating the Liquidating Trust Assets, including all offers of compromise and settlement with respect to such assets. Unless and until the First Priority Trust Beneficial Interests are paid in full, any decisions of the Liquidating Trustee to settle, compromise, affect, waive or release any rights of the Liquidating Trust in any assets having a nominal value of $50,000 or more (or such other minimum amount as may be agreed to by the Liquidating Trustee and the Master Trustee) shall require the consent of the Master Trustee, which consent may be withheld in its sole discretion. In the event that the Liquidating Trustee intends to decline an offer of compromise or settlement that would result in the payment in full of the First Priority Trust Beneficial Interests (any such offer, an "Exit

Offer"), such decision shall be made only if, in the reasonable determination of the Liquidating Trustee, there is a reasonable probability that a materially greater amount can be collected within a reasonable period of time. If the Master Trustee disagrees with the decision of the Liquidating Trustee to decline an Exit Offer, the Master Trustee may commence an expedited, confidential arbitration against the Liquidating Trustee and the Post-Effective Date Committee seeking a determination that the Liquidating Trustee has not acted reasonably in declining to accept such Exit Offer, and compelling the Liquidating Trustee to accept such Exit Offer.

(d) Resignation as Liquidating Trustee. The Liquidating Trustee may resign at any time upon not less than sixty (60) days' written notice to the Post-Effective Date Committee and the Post-Effective Date Board of Directors (if in existence at that time); provided, that the Post-Effective Date Committee and the Post-Effective Date Board of Directors may waive such notice requirement.

(e) Term as President of Post-Effective Date Debtors. The term of the Liquidating Trustee as president of the Post-Effective Date Debtors expires on the earlier of (i) twelve (12) months following the Effective Date or (ii) the expiration of the Interim Agreements, unless the Liquidating Trustee, with the consent of the Post-Effective Date Board of Directors, requests that the Court extend such term. Prior to the expiration of the term of the Liquidating Trustee as president of the Post-Effective Date Debtors, the Post-Effective Date Board of Directors may, in consultation with the Post-Effective Date Committee, terminate the Liquidating Trustee as president for cause.

(f) Replacement of the Liquidating Trustee. In the event that the Liquidating Trustee resigns, or in the event of the death of the Liquidating Trustee or other occurrence rendering the Liquidating Trustee incapacitated or unavailable for an extended period of thirty (30) consecutive days, a replacement Liquidating Trustee shall be appointed. If such appointment occurs prior to full payment of the First Priority Trust Beneficial Interests, the Post-Effective Date Committee shall appoint a replacement Liquidating Trustee in consultation with the Post-Effective Date Board of Directors, if such Board has not been disbanded, and with the consent of the Master Trustee, such consent not to be unreasonably withheld. If such appointment occurs after full payment of the First Priority Trust Beneficial Interests, the Post-Effective Date Committee shall appoint a replacement Liquidating Trustee in consultation with the Post-Effective Date Board of Directors, if such Board has not been disbanded. A notice of the identity of the new Liquidating Trustee shall be filed with the Bankruptcy Court promptly after the new Liquidating Trustee is appointed.

(g) No Further Approvals Required/Transfer of Liquidating Trust Assets. In performance of its duties hereunder, the Liquidating Trustee shall have the rights and powers of a debtor in possession under § 1107, and such other rights, powers, and duties necessary, appropriate, advisable or convenient to effectuate the provisions of the Plan. On and after the Effective Date, the Liquidating Trustee shall not be required to obtain any approvals from the Bankruptcy Court, any court or Governmental Unit and/or provide any notices under any applicable laws, including under the Nonprofit Laws, to implement the terms of the Plan, including, without limitation, the Transfer of any Liquidating Trust Assets retained by the Liquidating Trust. As further set forth in the Liquidating Trust Agreement, without limitation of the foregoing, with the prior Consent of the Master Trustee (until the First Priority Beneficial Trust Interests are paid in full) and the Post-

Effective Date Committee, the Liquidating Trustee shall be authorized pursuant to this Plan to Transfer any or all of the Liquidating Trust Assets without necessity of any further notice or approval of the Bankruptcy Court and/or under any applicable state or federal law, including under the Nonprofit Laws. This provision shall be subject in its entirety to the Liquidating Trust Agreement.

(h) Operation of Hospital Purchased Assets. The Liquidating Trustee shall be authorized (i) to continue to Operate the Hospital Purchased Assets pursuant to the Interim Agreements without necessity of any further notice or approval by the Bankruptcy Court, (ii) to execute any agreement or other instrument necessary to implement the terms of the SFMC Asset Purchase Agreement, the Seton Asset Purchase Agreement, the Transition Services Agreements, and the Interim Agreements, and (iii) to enforce the terms of the Interim Agreements and the Transition Services Agreements.

(i) Compensation. The Liquidating Trustee shall be compensated and reimbursed for his/her out-of-pocket expenses incident to the performance of his/her duties under the Plan as set forth in the Liquidating Trust Agreement, without further motion, application, notice or other order of the Bankruptcy Court. The fees and expenses of the Liquidating Trustee shall be satisfied solely out of the Liquidating Trust Administration Accounts.

6.6 ***Books and Records.*** As more fully set forth in the Liquidating Trust Agreement, the Liquidating Trustee shall maintain, with respect to the Liquidating Trust and the Trust Beneficiaries, books and records relating to the Liquidating Trust Assets and income of the Liquidating Trust and the payment of expenses of, and liabilities of claims against or assumed by, the Liquidating Trust in such detail and for such period of time as may be necessary to enable it to make full and proper accounting in respect thereof. Such books and records shall be maintained on a modified cash or other comprehensive basis of accounting necessary to facilitate compliance with the tax reporting requirements of the Liquidating Trust. Except as provided in the Liquidating Trust Agreement and the Plan, nothing requires the Liquidating Trustee to file any accounting or seek approval of any court with respect to the administration of the Liquidating Trust, or as a condition for managing any payment or distribution out of the Liquidating Trust Assets.

6.7 ***Payment of Trust Expenses.*** As set forth below, the Liquidating Trust expenses shall be paid, or adequate reserves created therefor, from the Liquidating Trust Administration Accounts.

6.8 ***Employment and Compensation of Professionals.*** In accordance with the Liquidating Trust Agreement, the Liquidating Trust may employ such counsel (which may be the same counsel employed by either the Post-Effective Date Committee or the Post-Effective Date Debtors), advisors and other professionals selected by the Liquidating Trustee that the Liquidating Trustee reasonably requires to perform its responsibilities under the Plan without further order from the Bankruptcy Court. The Liquidating Trust's professionals shall be compensated as agreed to by the Liquidating Trustee and paid upon five (5) Business Days' notice to the Post-Effective Date Committee, without further motion, application, notice or other order of the Bankruptcy Court. The fees and expenses of the Liquidating Trust's professionals shall be satisfied solely out of the Liquidating Trust Administrative Accounts.

6.9 ***Limitation of Liability of the Liquidating Trustee and the Post-Effective Date Committee.*** The Liquidating Trustee and the Post-Effective Date Committee, and the Liquidating Trustee's attorneys, accountants, consultants, employees, agents and assignees, shall have no liability for any error of judgment, actions, or omissions made in good faith other than as a result of gross negligence or willful misconduct. No provisions of this Plan shall require the Liquidating Trustee or any of the members of the Post-Effective Date Committee to expend or risk his/her own funds or otherwise incur personal financial liability in the performance of any of his/her duties under this Plan or in the exercise of any of the Liquidating Trustee's and the Post-Effective Date Committee's rights and powers. The Liquidating Trust shall indemnify and hold the Liquidating Trustee and Post-Effective Date Committee harmless, from and against any damages, costs, claims and other liabilities incurred by any of them in connection with their respective duties and responsibilities hereunder, other than those damages, costs, claims and other liabilities that result from such party's gross negligence or willful misconduct. Further, as provided in the Interim Agreements, Prime and AHMC shall indemnify and hold the Liquidating Trustee harmless, from and against any damages, costs, claims and other liabilities incurred by him/her in connection with the respective duties and responsibilities hereunder, other than those damages, costs, claims and other liabilities that result from the Liquidating Trustee's gross negligence or willful misconduct. The Liquidating Trustee may purchase or extend existing insurance to cover potential liabilities that may be incurred in the Chapter 11 Cases, and such cost shall be paid for by the Liquidating Trust from the Liquidating Trust Administration Accounts..

6.10 ***Termination of the Trust***. The Liquidating Trust will terminate on the earlier of: (a) thirty (30) days after the final distribution of the Liquidating Trust Assets in accordance with the terms of this Liquidating Trust Agreement and the Plan; and (b) the fifth (5th) anniversary of the Effective Date. Notwithstanding the foregoing, multiple fixed term extensions can be obtained so long as Bankruptcy Court approval is obtained within three (3) months before the expiration of the term of the Liquidating Trust and each extended term. The aggregate of all such extensions shall not exceed three (3) years, unless the Liquidating Trustee receives a favorable ruling from the IRS that any further extension would not adversely affect the status of the Liquidating Trust as a liquidating trust within the meaning of 26 C.F.R. § 301.7701-4(d) for federal income tax purposes. The Liquidating Trustee shall not unduly prolong the duration of the Liquidating Trust and shall at all times endeavor to resolve, settle or otherwise dispose of all claims that constitute Liquidating Trust Assets and to effect the distribution of the Liquidating Trust Assets to the Trust Beneficiaries in accordance with the terms hereof and terminate the Liquidating Trust as soon as practicable. Prior to and upon termination of the Liquidating Trust, the Liquidating Trust Assets will be distributed no less frequently than quarterly as set forth herein first, to the holder of the First Priority Trust Beneficial Interests until such Trust Beneficial Interests are paid in full, and second, to the holders, *pro rata*, of the Second Priority Trust Beneficial Interests until paid in full. Such distributions shall otherwise be made pursuant to the provisions set forth herein and in the Liquidating Trust Agreement. If any Liquidating Trust Assets are not duly claimed, such Liquidating Trust Assets will be distributed pursuant to Section 8.5. If there are still any Liquidating Trust Assets after a final distribution and payment of all expenses associated with the Liquidating Trust, such Liquidating Trust Assets will be disposed of in accordance with applicable law.

SECTION 7. MEANS FOR IMPLEMENTATION OF THE PLAN

7.1 ***Creditor Settlement Agreements***.

(a) Plan Settlement. Pursuant to Bankruptcy Rule 9019 and § 1123(b)(3)(A), the entry of the Confirmation Order shall constitute the Bankruptcy Court's approval, as of the Effective Date, of the Plan Settlement by and between the Debtors, the Prepetition Secured Creditors, and the Committee. The primary terms of the Plan Settlement are as follows:

(i) the Holders of Secured 2005 Revenue Bond Claims shall receive the treatment set forth in Section 4.5, including, but not limited to, the receipt of the Initial Secured 2005 Revenue Bonds Claims Payment and the First Priority Trust Beneficial Interests in full and final satisfaction of the 2005 Revenue Bonds Diminution Claim;

(ii) the Holders of Allowed General Unsecured Claims shall receive the treatment set forth in Section 4.9, including, but not limited to, the receipt of Second Priority Beneficial Trust Interests in full and final satisfaction of all Allowed General Unsecured Claims;

(iii) on the Effective Date, or as soon thereafter is reasonably practicable, the following litigations and the claims asserted therein shall be dismissed with prejudice: (a) the adversary proceeding captioned *Official Committee of Unsecured Creditors of Verity Health System of California, Inc., et al. v. U.S. Bank National Association, as trustee*, Adv. Case No. 2:19-ap-01165-ER (Bankr. C.D. Cal.); and (b) the adversary proceeding captioned *Official Committee of Unsecured Creditors of Verity Health System of California, Inc., et al. v. UMB Bank, National Association, as trustee*, Adv. Case No. 2:19-ap-01166-ER (Bankr. C.D. Cal.);

(iv) any outstanding stipulation or other agreement tolling the Committee's right to pursue claims against Verity MOB Financing, LLC and Verity MOB Financing II, LLC pursuant to the Final DIP Order and/or the Cash Collateral Orders shall be terminated and all further rights of the Committee with respect to such claims shall be waived, released, and terminated with prejudice;

(v) the Confirmation Order shall include, without limitation, findings that: (a) the Prepetition Secured Creditors were oversecured as of the Petition Date and are entitled to retain Adequate Protection Payments as allowed postpetition interest and fees under § 506(a); (b) the amount of the Prepetition Replacement Lien (as defined in the Final DIP Order and the Cash Collateral Orders) that may be asserted by the Master Trustee and the 2005 Revenue Bonds Trustee

is equal to or greater than the 2005 Revenue Bonds Diminution Claim; (c) the 2005 Revenue Bonds Claim, including the 2005 Revenue Bonds Diminution Claim, constitutes an Allowed Secured Claim for all purposes under the Plan and the Liquidating Trust Agreement, and on and after the Effective Date shall not be subject to any defense, reduction, setoff or counterclaim, including without limitation, pursuant to any claims under §§ 506(c) and 552(b) of the Bankruptcy Code; and (d) the Master Trustee and the 2005 Bonds Trustee are authorized to enter into the Plan Settlement on behalf of the holders of the 2005 Bonds Claims and such Trustees have properly exercised their rights, powers and discretion pursuant to the 2005 Bonds Indenture and applicable law in entering into the Plan Settlement, which shall be bind the Master Trustee, the 2005 Revenue Bonds Trustee and all holders of the 2005 Revenue Bonds Claims;

(vi) the Debtors and the Prepetition Secured Creditors shall waive any objection to the fees and expenses incurred by the Committee's advisors which exceed the limitations for investigating and prosecuting claims against the Prepetition Secured Creditors set forth in the Final DIP Order, the Cash Collateral Orders, the related budgets, and as set forth more fully in the Debtors' reservations of rights [Docket Nos. 3896, 4287]; provided, however, nothing herein shall be deemed a waiver of the rights of any party to object to the reasonableness of fees and/or expenses of the Committee;

(vii) the Master Trustee and the 2005 Revenue Bonds Trustee shall agree that, on the Effective Date, the Debtors shall pay, or reserve for, all Allowed and allowable Administrative Claims not otherwise paid in the ordinary course of the Debtors' operations notwithstanding that, absent such agreement, such Administrative Claims would not otherwise be entitled to any payment absent full payment of the 2005 Revenue Bonds Claim;

(viii) the Indenture Trustees and their affiliates shall be Released Parties under this Plan and shall be granted the benefit of the releases, injunctions, and exculpations set forth herein pursuant to § 1123(b)(3)(A) and the Plan Settlement; and

(ix) the Plan Settlement shall be effective provided that (a) the Confirmation Order is not subject to a stay of effectiveness on the Effective Date, and (b) Effective Date occurs on or before September 5, 2020.

The entry of the Confirmation Order shall constitute the Bankruptcy Court's finding that (i) entering into the Plan Settlement is in the best interests of the Debtors, their Estates, and their

creditors, (ii) the Plan Settlement is fair, equitable and reasonable, and (iii) the Plan Settlement meets all the standards set forth in Bankruptcy Rule 9019 and § 1123(b)(3)(A).

(b) PBGC Settlement. Pursuant to Bankruptcy Rule 9019 and § 1123(b)(3)(A), the entry of the Confirmation Order shall constitute the Bankruptcy Court's approval, as of the Effective Date, of the PBGC Settlement by and between the Debtors and the PBGC. The primary terms of the PBGC Settlement are as follows:

(i) the PBGC is granted a single, Allowed Administrative Claim against the Debtors in the total amount of $3,000,000 to be paid on the Effective Date;

(ii) the PBGC is granted a single, Allowed General Unsecured Claim against the Debtors in the total amount of $450,000,000;

(iii) the PBGC shall support confirmation of the Plan and entry of the Confirmation Order;

(iv) notwithstanding anything to the contrary in the Plan or Confirmation Order, any fiduciary breach claims held by the PBGC related to the Verity Health System Retirement Plan A and Verity Health System Retirement Plan B, shall not be not released, waived, or discharged under this Plan or the Confirmation Order;

(v) the PBGC Settlement shall be in full and final satisfaction of the PBGC Claims; and

(vi) the PBGC Settlement shall be null and void in the event that (A) the Plan is not confirmed or does not go into effect, or (B) the SFMC Sale or Seton Sale do not close.

The entry of the Confirmation Order shall constitute the Bankruptcy Court's finding that (i) entering into the PBGC Settlement is in the best interests of the Debtors, their Estates, and their creditors, (ii) the PBGC Settlement is fair, equitable and reasonable, and (iii) the PBGC Settlement meets all the standards set forth in Bankruptcy Rule 9019 and § 1123(b)(3)(A). Notwithstanding any provision in the Plan (including Section 13 hereof) or the Confirmation Order to the contrary, neither the Plan nor the Confirmation Order shall in any way be construed to discharge, release, limit, or relieve any party for a fiduciary breach related to the Verity Health System Retirement Plan A or Verity Health System Retirement Plan B. The PBGC, the Verity Health System Retirement Plan A, and the Verity Health System Retirement Plan B shall not be enjoined or precluded from enforcing such liability or responsibility by any of the provisions of the Plan or the Confirmation Order.

(c) Other Creditor Settlement Agreements. Pursuant to Bankruptcy Rule 9019 and § 1123(b)(3), the entry of the Confirmation Order shall constitute the Bankruptcy Court's approval, as of the Effective Date, of each of the Creditor Settlement Agreements and the finding that (i) entering into each of the Creditor Settlement Agreements is in the best interests of the Debtors, their Estates, and their creditors, (ii) each of the Creditor Settlement Agreements is fair,

equitable and reasonable, and (iii) each of the Creditor Settlement Agreements meets all the standards set forth in Bankruptcy Rule 9019 and § 1123(b)(3). Notwithstanding anything to the contrary set forth herein, all distributions contemplated by each Creditor Settlement Agreement shall be made only in accordance with the terms of the respective Creditor Settlement Agreement.

7.2 ***Deemed Substantive Consolidation***. The Plan contemplates, and is predicated on, the deemed substantive consolidation of the Debtors' Estates as follows:

(a) Entry of the Confirmation Order shall constitute the approval, pursuant to §§ 105(a), 541, 1123, and 1129, of the deemed substantive consolidation of the Debtors in the manner set forth herein. Notwithstanding such deemed substantive consolidation, however, fees payable, pursuant to 28 U.S.C. § 1930, shall be due and payable by each individual Debtor.

(b) The deemed substantive consolidation effected pursuant to the Plan shall not affect, without limitation, (i) the Debtors', the Post-Effective Date Debtors', or the Liquidating Trust's defenses to any Claim or Cause of Action, including the ability to assert any counterclaim, provided, that, the Liquidating Trust shall neither assert nor preserve Intercompany Claims, except to the extent necessary to preserve claims and defenses against any third parties other than the Debtors; (ii) the Debtors', the Post-Effective Date Debtors', or the Liquidating Trust's setoff or recoupment rights; (iii) requirements for any third party to establish mutuality prior to deemed substantive consolidation in order to assert a right of setoff against the Debtors, the Post-Effective Date Debtors, or the Liquidating Trust; (iv) distributions to the Debtors, the Estates, the Post-Effective Date Debtors, or the Liquidating Trust out of any Insurance Policies or proceeds of such policies; (v) distributions to the Debtors, the Estates, the Post-Effective Date Debtors, or the Liquidating Trust from any governmental programs, including, but not limited to, Medicare and Medi-Cal, including any fee for service payments and any Quality Assurance Payments; (vi) the applicability and enforceability of any government issued licenses, including, but not limited to, the Hospital Licenses, or (vii) any Avoidance Action or any other Cause of Action held by the Debtors arising under §§ 541 through 550, or state laws of similar effect, against any third party other than the other Debtors, except to the extent any such actions are expressly waived or settled pursuant to this Plan.

(c) The Disclosure Statement and the Plan shall be deemed to be a motion requesting that the Bankruptcy Court approve the deemed substantive consolidation contemplated by the Plan. Unless an objection to the proposed deemed substantive consolidation is made in writing by any creditor purportedly affected by such deemed substantive consolidation on or before the deadline to object to confirmation of the Plan, or such other date as may be fixed by the Bankruptcy Court, the deemed substantive consolidation contemplated by the Plan may be approved by the Bankruptcy Court at the Confirmation Hearing. In the event any such objections are timely filed, a hearing with respect thereto shall be scheduled by the Bankruptcy Court, which hearing may, but need not, be the Confirmation Hearing.

(d) If the Bankruptcy Court determines that deemed substantive consolidation of any given Debtors is not appropriate, then the Plan Proponents may request that the Bankruptcy Court otherwise confirm the Plan and approve the treatment of and Distributions to the different Classes under the Plan on an adjusted, Debtor-by-Debtor basis. Furthermore, the Debtors reserve their rights, with the consent of the Plan Proponents: (i) to seek confirmation of the Plan without

implementing deemed consolidation of any given Debtor, and, in the Debtors' reasonable discretion, to request that the Bankruptcy Court approve the treatment of and Distributions to any given Class under the Plan on an adjusted, Debtor-by-Debtor basis; and (ii) to seek deemed consolidation of all Debtors whether or not all Impaired Classes entitled to vote on the Plan vote to accept the Plan.

7.3 ***Cancellation of Existing Indentures and Related Securities***. On the Effective Date, and conditioned on the irrevocable receipt of all of the Plan payments to the respective Bond and Notes Trustees on behalf of Classes 2, 3, and 4 due upon the Effective Date, and the effectiveness of the releases and exculpations of each of the Indenture Trustees in accordance with Sections 13.5(d) and 13.7 of the Plan, the Master Indenture of Trust, dated as of December 1, 2001, as amended and supplemented, among the Daughters of Charity Health System, as predecessor in interest to VHS, the 2005 Revenue Bonds Indentures, the 2015 Revenue Notes Indentures and the 2017 Revenue Notes Indentures (collectively, the "***Indentures***"), together with the related Obligations of the Debtors, loan agreements and security documents to which the Debtors are party, including the Intercreditor Agreement, and the respective notes, bonds, and securities issued under each of the Indentures shall be deemed inoperative and unenforceable against the Debtors and the Debtors shall have no continuing obligations thereunder, and the Indenture Trustees shall each be discharged for all purposes, provided, however, that the foregoing Indentures shall continue in effect solely to the extent necessary to (i) allow the respective Bond and Notes Trustees to receive and make distributions under the Plan to their respective holders, and preserving the tax attributes of such distributions under such Indentures and (ii) allow the respective Indenture Trustees to enforce any obligations owed to them under the Plan or their respective Indentures (including compensation and reimbursement for any reasonable and documented fees and expenses pursuant to their respective charging liens as provided in the Indentures, as applicable). Without limiting the foregoing, the Bond and Notes Trustees, as applicable, shall receive all distributions made under the Plan on account of their respective Allowed Claims and shall distribute them in any manner permitted by the applicable Indentures, including on a date selected by the respective Bond and Notes Trustee on or after the Effective Date for surrender and cancellation of securities. The Indenture Trustees shall be entitled to receive from the Liquidating Trust their reasonable fees and expenses incurred in releasing any liens and making distributions, as applicable, in accordance with the relevant Indentures, the Plan, and the Confirmation Order. Notwithstanding the foregoing, if any claim is ever made upon the Indenture Trustees or any Prepetition Secured Creditor subject to the Intercreditor Agreement, which results in the rescission, repayment, recovery or restoration of any amounts received by the Indenture Trustees (or in the case of the Prepetition Secured Creditors, as distributed from the Indenture Trustees to such Prepetition Secured Creditor) pursuant to the Plan, the Intercreditor Agreement shall be reinstated in full force and effect, and the prior termination of the Intercreditor Agreement pursuant to this Section 7.3 shall not diminish, release, discharge, impair or otherwise affect the obligations of the parties to the Intercreditor Agreement from such date of reinstatement.

7.4 ***Funding for Distributions***. The distributions to holders of Allowed Claims and Trust Beneficiaries contemplated under the Plan shall be funded as set forth herein.

7.5 ***No Further Court Authorization***. Except as provided herein or the Confirmation Order, the Liquidating Trustee will continue the orderly administration of the Liquidating Trust Assets and otherwise implement the provisions of this Plan without necessity of any further order

of the Bankruptcy Court or approval or consent of any Governmental Unit, including under the Nonprofit Laws. Further, except as provided herein or the Confirmation Order, the Liquidating Trustee will continue his/her oversight and related responsibilities pursuant to the Plan and Interim Agreements without necessity of any further order of the Bankruptcy Court or other Governmental Unit, including under the Nonprofit Laws.

7.6 ***Operating Accounts for the Post-Effective Date Debtors***. On the Effective Date, subject to the prior payment of the amounts required to be paid by the Debtors in cash on the Effective Date pursuant to this Plan, Operating Accounts for Post-Effective Date Debtors shall be established and funded in accordance with, or, if previously established, continued in accordance with, the Operating Budget. The Liquidating Trustee shall be authorized to use the funds in the Operating Accounts to preserve, administer, and continue the Operations of the Operating Assets, including paying all costs and expenses associated therewith, and collection of any amounts due under the Interim Agreements, each in accordance with the Operating Budget. After the Effective Date, all Cash or other proceeds generated by the Operating Assets and required to fund the Operating Accounts and/or Operate the Operating Assets shall not be included within the definition of the Remaining Cash under this Plan.

7.7 ***Transfer of Certain Funds Into the Liquidating Trust***. Post-Effective Date, the Liquidating Trustee, subject to the prior payment of all amounts required to be paid by the Debtors in cash on the Effective Date pursuant to this Plan, shall transfer funds received on account of any Post-Effective Date Debtors to the Liquidating Trust except for funds that (i) constitute Hospital Purchased Assets, or (ii) are to be retained by the Post-Effective Date Debtors under the Interim Agreements and the Operating Budget. The aforementioned transfers to the Liquidating Trust shall be made as soon as practicable, but no less frequently than on a quarterly basis, with the first such transfer occurring as soon as practicable after the Effective Date. Further, the Liquidating Trustee shall transfer all funds held or received by SVMC, St. Vincent Dialysis, and the SCC Debtors on or after the Effective Date to the Liquidating Trust as soon as practicable, but no less frequently than on a quarterly basis, with the first such transfer occurring as soon as practicable after the Effective Date.

(a) Liquidating Trust Tax Matters. For all federal and applicable state and local income tax purposes:

(i) All parties must treat each transfer of Liquidating Trust Assets to the Liquidating Trust in accordance with the terms of the Plan and the Liquidating Trust Agreement.

(ii) All parties shall treat the Liquidating Trust as a grantor trust, of which the Trust Beneficiaries are the owners and grantors, and treat the Trust Beneficiaries as the direct owners of an undivided interest in Liquidating Trust Assets (other than any assets allocable to Liquidating Trust Reserves and the Liquidating Trust Administration Accounts), consistent with their economic interests therein.

(iii) Each transfer of Liquidating Trust Assets (other than any assets allocable to Liquidating Trust Reserves and the Liquidating Trust

Administration Accounts) to the Liquidating Trust shall be treated as a transfer of such assets directly to the holders of Trust Beneficial Interests in partial satisfaction of their Claims (with each Trust Beneficiary receiving an undivided interest in such assets in accord with their economic interests in such assets), followed by the transfer by the Trust Beneficiaries to the Liquidating Trust of such assets in exchange for the Trust Beneficial Interests.

(iv) The Liquidating Trustee will make a good faith valuation of the Liquidating Trust Assets. All parties must consistently use such valuation for all federal and applicable state and local income tax purposes.

(v) Allocations of the Liquidating Trust's taxable income (other than income attributable to assets in the Liquidating Trust Reserves and the Liquidating Trust Administration Accounts) among the beneficiaries of the Liquidating Trust shall be determined by reference to the manner in which an amount of Cash equal to such taxable income would be distributed (without regard to any restrictions on distributions) if, immediately prior to such deemed distribution, the Liquidating Trust had distributed all of its other assets (valued at their tax book value and other than assets allocable to Disputed Claims) to the Trust Beneficiaries, in each case up to the tax book value of the assets treated as contributed by such Trust Beneficiaries, adjusted for prior taxable income and loss and taking into account all prior and concurrent distributions from the Liquidating Trust. Similarly, taxable loss of the Liquidating Trust shall be allocated by reference to the manner in which an economic loss would be borne immediately after a liquidating distribution of the remaining Liquidating Trust Assets. The tax book value of the Liquidating Trust Assets for this purpose shall equal their fair market value on the date such assets are transferred to the Liquidating Trust, adjusted in accordance with tax accounting principles prescribed by the IRC, applicable Treasury Regulations, and other applicable administrative and judicial authorities and pronouncements.

(vi) The Liquidating Trustee shall file with the IRS returns for the Liquidating Trust as a grantor trust pursuant to 26 C.F.R. § 1.671-4(a). The Liquidating Trustee also shall annually send to each Trust Beneficiary a separate statement setting forth the Trust Beneficiary's share of items of income, gain, loss, deduction, or credit and shall instruct all of the Trust Beneficiaries to report such items on their federal income tax returns or to forward the appropriate information to such Trust Beneficiary's underlying beneficial holders with instructions to report such items on their federal income tax returns.

(vii) The Liquidating Trustee shall (x) treat the Liquidating Trust Reserves as "disputed ownership funds" governed by 26 C.F.R. § 1.468B-9 by timely making an election, and (y) to the extent permitted by applicable

law, report consistently with the foregoing for state and local income tax purposes.

(viii) The Liquidating Trustee shall be responsible for the payment, out of the Liquidating Trust, of any taxes imposed on the Liquidating Trust or the Liquidating Trust Assets, including the Liquidating Trust Reserves.

7.8 ***Funding of the Liquidating Trust Administration Accounts.*** On or prior to the Effective Date, the Liquidating Trustee shall have the authority, subject to the Liquidating Trust Agreement, to establish and maintain one or more Liquidating Trust Administration Accounts in the name of the Liquidating Trustee pursuant to the terms of this Plan and the Liquidating Trust Agreement. On the Effective Date, an amount of the Debtors' Cash on hand equal to an aggregate of $3,500,000.00 shall be deposited in the Liquidating Trust Administration Accounts as designated by the Liquidating Trustee. The Liquidating Trustee shall have the authority, subject to the Liquidating Trust Agreement, to utilize the funds in the Liquidating Trust Administration Account to pay any and all reasonable costs and expenses incurred in implementing the terms of this Plan and the Liquidating Trust Agreement, including, but not limited to, the costs of collection and liquidation of the Liquidating Trust Assets. et. As assets are collected by the Liquidating Trust, at least 95% of the gross amount of such collections shall be deposited into the Plan Fund, to be paid to the Master Trustee for application against the First Priority Trust Beneficial Interests until the 2005 Revenue Bonds Diminution Claim is paid in full, and the remainder of such gross collections may be retained by the Liquidating Trust and deposited into the Liquidating Trust Administration Account; provided, that, if and when the aggregate of the deposits into the Liquidating Trust Administration Account, including the initial $3,500,000.00 deposit, equals $7,500,000.00, 100% of all subsequent gross collections shall be deposited into the Plan Fund, to be paid to the Master Trustee for application to the First Priority Trust Beneficial Interests until paid in full, and then shall be used to make payments to the Holders of the Second Priority Trust Beneficial Interests. Upon termination of the Liquidating Trust, if any of the 2005 Revenue Bonds Diminution Claim remains unpaid, any balance in the Liquidating Trust Administration Account shall be paid to the Master Trustee on account of the First Priority Trust Beneficial Interests until the 2005 Revenue Bonds Diminution Claim is paid in full, and any remaining balance in the Liquidating Trust Administration Account shall thereafter be paid to the Holders of the Second Priority Trust Beneficial Interests.

7.9 ***Liquidating Trust Reserves***. The Liquidating Trustee shall have the authority to establish and maintain the Liquidating Trust Reserves, as follows:

(a) Disputed Unclassified Claims and Disputed Class 1A Claims Reserves.

(i) *Establishment.* On the Effective Date, the Liquidating Trustee shall set aside Cash sufficient in the aggregate to fund a reserve on account of any Disputed Unclassified Claims and Disputed Class 1A Claims. Once such Disputed Unclassified Claims and Disputed Class 1A Claims, if any, are resolved and become Allowed, Cash in such reserves shall be made available, on a quarterly basis, for distribution to the holders of such newly Allowed Claims in accordance with the Plan. If all Disputed Unclassified Claims and Disputed Class 1A Claims are either Allowed and satisfied or

Disallowed, any remaining funds in such reserve, on a quarterly basis, shall be used to first fund the Trust Administration Account (if necessary) and the remainder shall be deposited into the Plan Fund.

(ii) *Funding Amount.* The Liquidating Trustee may reserve on account of any Disputed Unclassified Claims and Disputed Class 1A Claims based on the face amount of the Disputed Claim Holder's Proof of Claim (or if no Proof of Claim was filed, the amount set forth in the Debtors' Schedules with respect to such Disputed Claim or application for payment, as applicable) or request that the Bankruptcy Court estimate the amount of any Disputed Claim pursuant to § 502(c), in which event the amount so estimated shall be deemed the amount of the Disputed Claim for purposes of funding the Disputed Claims Reserves.

(b) Effective Date Professional Claim Reserves. For the Professional Claims not yet fixed and Allowed by the Bankruptcy Court prior to or on the Effective Date, the Liquidating Trustee shall establish the Effective Date Professional Claim Reserve. If all Professional Claims are Allowed and satisfied, any funds remaining in the Effective Date Professional Claim Reserve shall be used to first fund the Trust Administration Account (if necessary) and the remainder shall be deposited into the Plan Fund.

(c) Disputed Unsecured Claims Reserve. As more fully set forth below in Section 7.10(b), and solely from the Plan Fund, the Liquidating Trustee shall reserve for Disputed General Unsecured Claims until such Claims are reconciled and either Allowed or Disallowed. Amounts held in the Disputed Unsecured Claims Reserve shall be transferred into the unreserved portion of the Plan Fund for distribution to Allowed General Unsecured Claims upon determination of the General Unsecured Claim's status as Allowed or Disallowed.

(d) Administrative Claims Reserve. As more fully set forth below in Section 15.3, on the Effective Date, the Debtors shall establish the Administrative Clams Reserve. Upon satisfaction of all Allowed Administrative Claims and resolution of any disputed Administrative Claims for which amounts were included in the Administrative Claims Reserve, any funds remaining in the Administrative Claims Reserve shall be deposited into the Plan Fund.

7.10 ***Plan Fund***.

(a) Establishment of the Plan Fund. On the Effective Date or as soon as practicable thereafter, subject to the prior payment of all amounts required to be paid by the Debtors on the Effective Date pursuant to this Plan, the Liquidating Trustee shall fund the Plan Fund with the Remaining Cash after funding (i) the Liquidating Trust Reserves and (ii) Liquidating Trust Administration Accounts. The proceeds of the Plan Fund shall be used to make distributions as follows: (i) first, to pay the 2005 Revenue Bonds Diminution Claim, which shall have a First Priority Trust Beneficial Interest in the Plan Fund; and (ii) second, to pay Allowed General Unsecured Claims, which shall have Second Priority Trust Beneficial Interest in the Plan Fund. As Disputed General Unsecured Claims are resolved and become Allowed, Cash in the Disputed Unsecured Claims Reserve shall be transferred into the unreserved portion of the Plan Fund and

made available for distribution to the Holders of such newly Allowed General Unsecured Claims in an amount of their Pro Rata Share in accordance with the Plan.

(b) Funding Amount. After full Payment of the First Priority Trust Beneficial Interests, the Liquidating Trustee may either (i) reserve on account of Disputed General Unsecured Claims an amount necessary to satisfy such claims once they are Allowed, which shall be based upon the estimated distribution percentage for all Allowed General Unsecured Claims (using either the face value of the Proofs of Claim, or if no Proof of Claim was required to be filed, the amount reflected in the Schedules), (ii) reserve an amount as estimated by agreement between the Debtors or the Liquidating Trustee and the Holder of such Disputed General Unsecured Claim, or (iii) in the absence of such an agreement, reserve the amount estimated by the Bankruptcy Court under § 502(c).

(c) Restrictions on Use of Plan Fund. Funds in the Plan Fund shall be used solely to make payments to the Holders of Trust Beneficial Interests from time to time as required by the terms of the Plan and the Liquidating Trust Agreement, and no funds in the Plan Fund shall be used for the costs of administration of the Liquidating Trust or for any other purpose, including the costs of collection and liquidation of the Liquidating Trust Assets.

7.11 ***Post-Effective Date Committee***.

(a) Dissolution of the Committee. On the Effective Date, the Committee shall be dissolved (except with respect to any Professional compensation matters), and the members, employees, agents, advisors, affiliates, and representatives (including, without limitation, attorneys, financial advisors, and other professionals) of each thereof shall thereupon be released from and discharged of and from all further authority, duties, responsibilities, and obligations related to, arising from and in connection with or related to the Chapter 11 Cases; provided, however, that obligations arising under confidentiality agreements, joint interest agreements, and protective orders, if any, entered during the Chapter 11 Cases shall remain in full force and effect according to their terms. The Liquidating Trust shall continue to compensate the Post-Effective Date Committee's professionals, in the ordinary course of business and without the need for Bankruptcy Court approval, for reasonable services provided in connection with any of the foregoing post-Effective Date activities out of the Liquidating Trust Administration Accounts.

(b) Formation of the Post-Effective Date Committee. On the Effective Date, the Post-Effective Date Committee shall be appointed. Other than the Master Trustee, which shall be an ex officio and non-voting member of the Post-Effective Date Committee, the initial members that shall serve on the Post-Effective Date Committee shall be selected by the Committee and shall be disclosed in a Plan Supplement.

(c) Duties. The Post-Effective Date Committee shall have duties in accordance with the Plan and the Liquidating Trust Agreement: (i) consult and coordinate with the Liquidating Trustee as to the administration of the Liquidating Trust and the Liquidating Trust Assets, including without limitation, consulting on the Operating Budget; and (ii) consult and coordinate with the Liquidating Trustee as to the administration of the Post-Effective Date Debtors.

(d) Resignation. Any member of the Post-Effective Date Committee may resign at any time upon not less than thirty (30) days' written notice to the Post-Effective Date Committee with a copy of such notice to the Liquidating Trustee; provided, that, the Post-Effective Date Committee may waive such notice period. Any member of the Post-Effective Date Committee may be removed in accordance with any by-laws governing the actions of the Post-Effective Date Committee.

(e) Replacement. In the event that a member of the Post-Effective Date Committee resigns or is duly terminated or unable to serve as a member thereof, then a successor member shall be selected by the remaining members of the Post-Effective Date Committee, in consultation with Post-Effective Date Debtors; provided, however, that if no agreement on the replacement member can be reached or if there are fewer than two (2) members remaining on the Post-Effective Date Committee, the parties shall request that the Bankruptcy Court resolve such dispute and/or appoint the replacement member(s).

(f) Termination of the Post-Effective Date Committee. The Post-Effective Date Committee shall continue in existence until such time as either the Post-Effective Date Committee deems it appropriate by a majority vote to dissolve itself or all members of the Post-Effective Date Committee resign; provided, however, that the Post-Effective Date Committee shall automatically dissolve upon the closing of the Chapter 11 Cases in accordance with the terms of Section 8.9.

7.12 ***Coordination Between Post-Effective Date Debtors and the Liquidating Trust***. Notwithstanding anything herein to the contrary, in furtherance of the purposes of the Liquidating Trust, at the request of the Liquidating Trustee, the Post-Effective Date Debtors (including, without limitation, the Post-Effective Date Debtors' employees, agents and/or professionals) shall be authorized to provide assistance and services to, or otherwise act on behalf of, the Liquidating Trustee in the performance of the Liquidating Trustee's duties under the Plan and the Liquidating Trust Agreement. Without limitation on the foregoing, the Post-Effective Date Debtors shall be authorized to assist in the reconciliation and administration of claims, and assist in the liquidation and/or collection of Liquidating Trust Assets (including, without limitation, litigation claims). The Liquidating Trustee shall oversee all such services provided on behalf of the Liquidating Trustee.

7.13 ***Destruction and Abandonment of Books and Records***. Subject to the terms of the Records Retention Order with respect to the records covered thereby, on or after the Effective Date, pursuant to § 554(a), the Liquidating Trustee is each authorized, from time to time, without further application to the Bankruptcy Court or notice to any party, to abandon or otherwise destroy documents and records (whether in electronic or paper format) that he or she determine, in his/her reasonable business judgment, are no longer necessary to the administration of either the Chapter 11 Cases or the Plan, notwithstanding any federal, state, or local law or requirement requiring the retention of the applicable documents or records; provided, that, 60 days prior to any abandonment or destruction, the Liquidating Trustee will give notice to any Insurer requesting notice prior to the Confirmation Date and a general description of the documents to be abandoned or destroyed, and the Insurer shall have 30 days thereafter to request, at its expense, copies of the documents relevant to the defense or indemnity claims covered by that Insurer. The Insurer and the Liquidating Trustee shall cooperate in limiting the request to document relevant to defense or indemnity of claims covered by that Insurer. The Liquidating Trustee shall comply with and shall not modify

the Records Retention Order without (i) the prior consent of the Post-Effective Date Committee or (ii) upon motion to the Bankruptcy Court with notice and an opportunity to be heard.

7.14 ***Preservation of Insurance.*** Nothing in this Plan shall diminish, impair or otherwise affect payments from the proceeds or the enforceability of any Insurance Policies that may cover (a) Claims by any Debtor, or (b) Claims against any Debtor or covered Persons thereunder.

7.15 ***Mutuality preserved.*** Unless specifically agreed in writing by the Debtors or the Liquidating Trustee, as applicable, nothing in the Plan constitutes a waiver of the mutuality requirement for setoff under § 553 and each Debtor shall be treated independently for mutuality and setoff purposes.

SECTION 8. DISTRIBUTIONS

8.1 ***Party Responsible for Making Distributions***. Subject to the prior payment of the amounts required to be paid by the Debtors in Cash on the Effective Date pursuant to this Plan, the Liquidating Trustee shall be charged with making distributions under the Plan with respect to all Allowed Claims as set forth herein.

8.2 ***Appointment of Disbursing Agent***. A Disbursing Agent may be identified in the Disclosure Statement or appointed pursuant to the Confirmation Order.

8.3 ***Timing of Distributions***.

(a) Distributions on Account of All Claims Other Than the 2005 Revenue Bonds Diminution Claim and the General Unsecured Claims. Subject to Section 8.1 of this Plan, the Liquidating Trust shall make all payments and distributions required to be made under the Plan on account of Allowed Claims, which may be made by the Liquidating Trustee, or by the Disbursing Agent, if a Disbursing Agent has been appointed under the Plan. Unless otherwise provided herein, all distributions on account of Allowed Claims, other than the 2005 Revenue Bonds Diminution Claim and the General Unsecured Claims, shall be made as soon as practicable on or after the Effective Date. In each case, such payments or distributions shall be made no later than the later of (i) ten (10) days after the Effective Date, or (ii) the date on which the Liquidating Trustee determines that the Liquidating Trust holds sufficient Cash; provided, however, that for any employee continuing to provide services to the Liquidating Trustee, solely with respect to any Allowed Unclassified Claims for paid time off and severance, the "Effective Date" for purposes of making such distributions shall be deemed to mean each individual employee's last date of employment with the Liquidating Trustee.

(b) Distributions on Account of the 2005 Revenue Bonds Diminution Claim and the General Unsecured Claims. Distributions on account of Allowed Claims in Class 4 and Class 8 shall be made exclusively on account of Trust Beneficial Interests at least quarterly, provided, however, that distributions need not be made to the extent there is no Cash in the Plan Fund to distribute.

8.4 ***Withholding of Distributions***. Other than amounts paid to the Indenture Trustees, all distributions under the Plan and all related agreements shall be subject to any applicable

withholding and reporting requirements. In addition to any other withholding authorized hereunder, in the case of a Cash distribution that is subject to withholding, the Liquidating Trustee may withhold from amounts distributable on account of Allowed Claims any and all amounts determined in the Liquidating Trustee's sole discretion to be required by any law, regulation, rule, ruling, directive or other governmental requirement. In the case of a non-Cash distribution that is subject to withholding, the distributing party may withhold an appropriate portion of such distributed property and sell such withheld property to generate Cash necessary to pay over the withholding tax. Holders of Allowed Claims shall, as a condition to receiving distributions, provide such information and take such steps as the Liquidating Trustee may reasonably require to enable it to comply with the withholding and reporting requirements and to obtain certifications and information as may be necessary or appropriate to satisfy the provisions of any tax law. Notwithstanding the foregoing, each holder of an Allowed Claim that receives a distribution under the Plan shall have the sole and exclusive responsibility for any taxes imposed by any Governmental Unit, including income, withholding, and other taxes, on account of such distribution.

8.5 ***Delivery of Distributions and Undeliverable Distributions***. Other than distributions made to the Indenture Trustees, which shall be by wire transfer in accordance with instructions provided to the Liquidating Trustee, subject to Bankruptcy Rule 9010, all distributions to any holder of an Allowed Claim shall be made at the address of such holder as set forth on either the Schedules or the books and records of the Debtors, unless the Liquidating Trustee has otherwise been notified by the holder in writing of a change of address, including, without limitation, by the filing of a Proof of Claim by such holder that contains an address for such holder different from the address reflected on either the Schedules or the books and records. In the event that any distribution to any holder is returned as undeliverable, no further distributions to such holder shall be made unless and until the Liquidating Trustee is notified of such holder's then-current address, at which time all missed distributions shall be made to such holder, without interest. At the option of the Liquidating Trustee, any Cash payment to be made hereunder may be made by a check or wire transfer or as otherwise required or provided in applicable agreements. Checks issued by the Liquidating Trustee in respect of Allowed Claims shall be null and void if not negotiated within ninety (90) days after the date of issuance thereof. All demands for undeliverable distributions (including requests for re-issuance of any voided check) shall be made to the Liquidating Trustee on or before sixty (60) days after the expiration of the ninety (90) day period after the date such undeliverable distribution was initially made or the check was originally issued, as applicable. Thereafter, the amount represented by such undeliverable distribution (including a voided check) shall be deemed forfeited, and any Claim in respect of such undeliverable distribution (including a voided check) shall be Disallowed, discharged and forever barred from asserting any such Claim against each Released Party, the Post-Effective Date Debtors, the Liquidating Trustee, the Post-Effective Date Committee, and the Liquidating Trust. Any distributions that are forfeited or otherwise cancelled shall be made available for re-distribution to other Trust Beneficiaries (other than those whose distributions are deemed undeliverable hereunder) in accordance with the Plan, and shall not be subject to the unclaimed property or escheat laws of any Governmental Unit.

8.6 ***Setoffs***. For purposes of determining the Allowed amount of a Claim on which distribution shall be made, the Liquidating Trustee may, but shall not be required to, setoff against any respective Claim administered by it, any claims of any nature whatsoever that the Debtors may have against the holder of such Claim, but neither the failure to do so nor the allowance of any

Claim hereunder shall constitute a waiver or release by the Liquidating Trustee of any such setoff claim(s); provided, however, that the Secured 2017 Revenue Notes Claims, the Secured 2015 Revenue Notes Claims, the Secured 2005 Revenue Bond Claims, the Secured MOB I Financing Claims, and the Secured MOB II Financing Claims shall be deemed to be Allowed Claims and shall not be subject to any setoff.

8.7 ***De Minimis Distributions***. No distribution is required to be made to a Holder of an Allowed Claim if the amount of Cash to be distributed on any distribution date under the Plan on account of such Claim is $50 or less. Any Holder of an Allowed Claim on account of which the amount of Cash to be distributed is $50 or less will have its Claim for such distribution discharged and will be forever barred from asserting any such Claim against each Released Party, the Post-Effective Date Debtors, the Liquidating Trustee, the Post-Effective Date Committee, and the Liquidating Trust. Any Cash not distributed pursuant to this Section will, in the Liquidating Trustee's discretion, be included in the Liquidating Trust Reserves and/or the Plan Fund, free of any restrictions thereon, and will be distributed in accordance with the Plan.

8.8 ***Allocation of Plan Distribution Between Principal and Interest***. All distributions by the Liquidating Trustee with respect to any Allowed Claim, with the exception of the Secured 2005 Revenue Bond Claim, shall be allocated first to the principal amount of such Allowed Claim, as determined for federal income tax purposes, and thereafter, to the remaining portion of such Allowed Claim (including the interest portion of the Allowed Claim), if any.

8.9 ***Entry of Final Decree in Chapter 11 Cases***. Once all the Disputed Claims have become Allowed Claims or have been disallowed by Final Order, and all distributions in respect of Allowed Claims have been made in accordance with this Plan, or at such earlier time as the Liquidating Trustee deems appropriate, the Liquidating Trustee (i) shall seek authority from the Bankruptcy Court for entry of final decrees closing the Chapter 11 Cases in accordance with the Bankruptcy Code and the Bankruptcy Rules and (ii) shall be authorized under the Plan to take any necessary corporate action with respect to the Debtors' continued existence without the necessity for approvals or notices under any applicable state or other law, including under the Nonprofit Laws. Notwithstanding the foregoing, actions with respect to the Post-Effective Date Debtors shall be taken by the Liquidating Trustee. The entry of final decrees closing these Chapter 11 Cases shall not affect the Nonprofit Status of the Post-Effective Date Debtors to the extent they have not dissolved in accordance with the Plan.

SECTION 9. TRUST BENEFICIARIES

9.1 ***Identification of Trust Beneficiaries***. Each of the Trust Beneficiaries shall be recorded and set forth in a schedule maintained by the Liquidating Trustee expressly for such purpose based upon its Allowed Claim in Class 4 or Class 8.

9.2 ***Beneficial Interests Only***. The ownership of Trust Beneficial Interests shall not entitle any Trust Beneficiary to any title in or to the Liquidating Trust Assets or to any right to call for a partition or division of such Liquidating Trust Assets or to require an accounting, except as may be specifically provided herein.

9.3 ***Ownership of Beneficial Interests Hereunder***. Subject to the requirements and limitations of this Plan, including the establishment of the Liquidating Trust Reserves and Liquidating Trust Administration Accounts: (i) the Holder of the First Priority Trust Beneficial Interest shall have an undivided first priority interest in the Liquidating Trust equal to the amount of the 2005 Revenue Bonds Diminution Claim as of the Effective Date, provided however that the amount of such First Priority Trust Beneficial Interest shall be limited, on any given measurement date, to the lesser of (a) the value of the Plan Fund or (b) the unpaid balance of the 2005 Revenue Bonds Diminution Claim, including accrued but unpaid interest thereon; and (ii) each Holder of a Second Priority Trust Beneficial Interest shall own an undivided interest in the Liquidating Trust equal in proportion to such Trust Beneficiary's Pro Rata Share of Allowed Claims in Class 8.

9.4 ***Evidence of Beneficial Interests***. Ownership of a Trust Beneficial Interest (a) shall be noted in the books and records of the Liquidating Trust and (b) shall not be evidenced by any certificate, note, or receipt or in any other form or manner whatsoever, except as maintained on the books and records of the Liquidating Trust by the Liquidating Trustee, including the Schedule.

9.5 ***Conflicting Claims***. Except as otherwise provided in the Liquidating Trust Agreement, if any conflicting claims or demands are made or asserted with respect to a beneficial interest, the Liquidating Trustee shall be entitled, at its sole election, to refuse to comply with any such conflicting claims or demands. In so refusing, the Liquidating Trustee may elect to make no payment or distribution with respect to the beneficial interest represented by the claims or demands involved, or any part thereof, and the Liquidating Trustee shall refer such conflicting claims or demands to the Bankruptcy Court, which shall have exclusive jurisdiction over resolution of such conflicting claims or demands. In so doing, the Liquidating Trustee shall not be or become liable to any party for his/her refusal to comply with any of such conflicting claims or demands. The Liquidating Trustee shall be entitled to refuse to act until either (a) the rights of the adverse claimants have been adjudicated by a Final Order or (b) all differences have been resolved by a written agreement among all of such parties and the Liquidating Trustee, which agreement shall include a complete release of the Liquidating Trust and the Liquidating Trustee (the occurrence of either (a) or (b) being referred to as a "Dispute Resolution" in this Section 9). Until a Dispute Resolution is reached with respect to such conflicting claims or demands, the Liquidating Trustee shall hold in a segregated interest-bearing account with a United States financial institution any payments or distributions from the Liquidating Trust to be made with respect to the Beneficial Interest at issue. Promptly after a Dispute Resolution is reached, the Liquidating Trustee shall transfer the payments and distributions, if any, held in the segregated account, together with any interest and income generated thereon, in accordance with the terms of such Dispute Resolution.

9.6 ***Limitation on Transferability***. As set forth in more detail in the Liquidating Trust Agreement, the Trust Beneficial Interests may not be transferred, sold, assigned, hypothecated, or pledged, except as they may be assigned or transferred by will, intestate succession, or operation of law.

SECTION 10. PROCEDURES FOR TREATING AND RESOLVING DISPUTED CLAIMS

10.1 ***Objection to Claims***. Unless otherwise ordered by the Bankruptcy Court after notice and a hearing, and except as otherwise expressly provided herein, the Liquidating Trustee,

in consultation with the Post-Effective Date Committee, shall have the exclusive right to file, prosecute, resolve and otherwise deal with objections to Claims other than Allowed Claims pursuant to this Plan or a Final Order. The Liquidating Trustee shall serve a copy of each Claim objection upon the holder of the Claim to which the objection is made. Claims objections with respect to all Claims shall be made as soon as reasonably practical but in no event later than the Claims Objection Deadline. If the Liquidating Trustee wishes to extend the Claims Objection Deadline, it may do so pursuant to a motion, to be filed with the Bankruptcy Court, on notice to the Post-Effective Date Committee, which may be approved without a hearing.

10.2 ***Disallowed Claims***. The following Claims shall be automatically Disallowed and expunged, without the need for filing any objections thereto, and shall not be entitled to any distributions under the Plan: (a) Claims for which no Proof of Claim was filed by the applicable Bar Date even though such Claims were listed on the Schedules as disputed, contingent, or unliquidated; and (b) Claims covered by § 502(d) to the extent that the holder of such Claim has not been paid the amount or turned over the property for which such holder is liable under §§ 522(i), 542, 543, 550, or 553, in accordance with § 502(d).

10.3 ***No Distribution Pending Allowance***. Notwithstanding any other provision of this Plan, if any portion of a Claim is Disputed, no payment or distribution provided hereunder shall be made on account of such Claim unless and until such Disputed Claim becomes an Allowed Claim.

10.4 ***Distributions After Allowance***. Any Claim (or portion thereof) that is Disputed and then subsequently Allowed, shall be an Allowed Claim, not a Disputed Claim, in such amount and to the extent it is subsequently Allowed. Except as otherwise provided herein, if, on or after the Effective Date, any Disputed Claim becomes an Allowed Claim, the Liquidating Trustee shall distribute to the Holder of such Allowed Claim, from the applicable fund or reserve in accordance with Sections 7.9, 7.10, and 8.3, the amount such holder would have received had its Claim been Allowed on the Effective Date as determined by distributions actually made to other holders of Allowed Claims.

10.5 ***Disputed Claims***.

(a) Resolution of the Disputed Claims.

(i) From and after the Effective Date, the Liquidating Trust shall have the exclusive authority to compromise, resolve, and deem Allowed any Disputed Claim without the need to obtain approval from the Bankruptcy Court, and any agreement entered into by the Liquidating Trust with respect to the Allowance of any Claim shall be conclusive evidence and a final determination of the Allowance of such Claim, except as set forth below in (ii) of this Section 10.5(a);

(ii) The Liquidating Trustee shall notify the Post-Effective Date Committee prior to settling, compromising, or allowing any Disputed Claim in an liquidated amount in excess of $250,000 for a General Unsecured Claim and $100,000 for an Unclassified Claim, Secured Claim, or Priority

Non-Tax Claim. The Post-Effective Date Committee shall have three (3) Business Days after receipt of such notice to review the proposed settlement or compromise of such Claim. If such objection is made, the Liquidating Trustee shall not move forward with the matter absent Court approval after at least ten (10) Business Days' notice and opportunity to object to the Post-Effective Date Committee; and

(iii) If the Liquidating Trustee and the holder of a Disputed Claim are unable to reach settlement of the Disputed Claim, such Disputed Claim shall be submitted to the Bankruptcy Court for resolution. If it is determined that the Bankruptcy Court does not have jurisdiction to resolve any Disputed Claim, then the Disputed Claim shall be submitted to the District Court for resolution.

(b) Estimation of Disputed Claims. The Liquidating Trustee may at any time request that the Bankruptcy Court estimate any Disputed Claim pursuant to § 502(c) regardless of whether the Debtors or the Liquidating Trustee previously objected to such Claim, and the Bankruptcy Court shall retain jurisdiction to estimate any Claim at any time during litigation concerning any objection to any Claim, including, without limitation, during the pendency of any appeal relating to any such objection. In the event that the Bankruptcy Court estimates any Disputed Claim, the amount so estimated shall constitute either the Allowed amount of such Claim or a maximum limitation on such Claim, as determined by the Bankruptcy Court. If the estimated amount constitutes a maximum limitation on the amount of such Claim, the Liquidating Trustee, as applicable, may pursue supplementary proceedings to object to the allowance of such Claim. On and after the Effective Date, Claims that have been estimated may be compromised, settled, withdrawn, or otherwise resolved, without further order of the Bankruptcy Court.

10.6 ***Cumulative Effect***. All the objection, estimation, and resolution procedures set forth in this Section are intended to be cumulative (where possible) and not exclusive of one another.

SECTION 11. EXECUTORY AGREEMENTS

11.1 ***General Treatment***. On the Effective Date, all Executory Agreements to which any Debtor is a party shall be deemed rejected as of the Effective Date, except for those Executory Agreements that (a) have been assumed or rejected pursuant to a Final Order of the Bankruptcy Court (including pursuant to any Sale Order), (b) are the subject of a separate motion to assume, assume and assign, or reject filed under § 365 on or before the Effective Date, or (c) are specifically designated as a contract or lease to be assumed on the Schedule of Assumed Contracts and no timely objection to the proposed assumption has been filed, provided, however, that the Debtors shall, no later than five (5) business days prior to the Confirmation Hearing, provide Cigna (as that term is defined in Docket No. 4927) with written notice of its irrevocable decision as to whether or not the Debtors propose to assume or reject each of the Cigna Contracts (as that term is defined in Docket No. 4927) as part of the Plan. If the party to an Executory Agreement listed to be assumed in the Schedule of Assumed Contracts wishes to object to the proposed assumption (including with respect to the cure amounts), it shall do so within thirty (30) days from the service of the Schedule of Assumed Contracts.

11.2 ***Bar Date for Rejection Damages***. Claims arising out of the rejection of an Executory Agreement pursuant to the Plan must be filed with the Bankruptcy Court (or as otherwise provided for in the Debtors' notice of rejection) no later than thirty (30) days after the Effective Date. Any Claims not filed within such time period will be forever barred from assertion against the Debtors and/or their property and/or their Estates.

11.3 ***Insurance Policies.*** For the avoidance of doubt, the Debtors' rights with respect to all Insurance Policies under which Debtors may be an insured beneficiary or assignee (including all Insurance Policies that may have expired prior to the Petition Date, all Insurance Policies in existence on the Petition Date, all Insurance Policies entered into by the Debtors after the Petition Date, and all Insurance Policies under which the Debtors hold rights to make, amend, prosecute, and benefit from claims) shall be transferred to the Liquidating Trust (including, without limitation, for the Liquidating Trustee to pursue and prosecute any Causes of Action) on the Effective Date, unless any such Insurance Policy is otherwise cancelled by the Liquidating Trustee in its discretion. Notwithstanding any provision providing for the rejection of Executory Agreements, any Insurance Policy that is deemed to be an Executory Agreement shall neither be rejected nor assumed by operation of this Plan and shall be the subject of a specific motion by the Liquidating Trust, which shall retain the right to assume or reject any such Executory Agreements pursuant to and subject to the provisions of § 365 following the Effective Date, with all rights of the Insurers to object or otherwise contest such assumption or rejection being expressly reserved provided, that, the Liquidating Trustee may not reject (a) any extended reporting period (tail) coverage purchased by the Debtors and (b) any Insurance Policies assumed by the Debtors pursuant to an order of the Bankruptcy Court.

The Confirmation Order shall constitute a determination that no default by the Debtors exists with respect to any of the Insurance Policies requiring a cure payment and that nothing in a Sale Order, any underlying agreements or this Plan shall be construed or applied to modify, impair, or otherwise affect the enforceability of the Insurance Policies or any coverage thereunder with regard to any Claims or Causes of Action. Notwithstanding any other provision of this Section, Old Republic Insurance Company is entitled to all accommodations that it requested in connection with renewal of the Debtors' workers' compensation policy as approved by the Bankruptcy Court [Docket No. 2803].

Notwithstanding anything to the contrary in the Confirmation Order or the Plan (including any other provision that purports to be preemptory or supervening), nothing shall in any way operate to impair, or have the effect of impairing the Insurers' legal, equitable or contractual rights, if any, in respect of any Claims (as defined by § 101(5)), and the rights of Insurers shall be determined under the Insurance Policies and under applicable nonbankruptcy law; provided that any Claim by an Insurer against a Debtor or the Liquidating Trust shall also be determined under applicable bankruptcy law, and Plan and Confirmation Order provisions.

Nothing in the Plan or in the Confirmation Order shall preclude any Person from asserting in any proceeding any and all Claims, defenses, rights or causes of action that it has or may have under or in connection with any Insurance Policy, and nothing in the Plan or the Confirmation Order shall be deemed to waive any claims, defenses, rights or causes of action that any Person (including any Insurer) has or may have under the provisions, terms, conditions, defenses and/or exclusions contained in the subject Insurance Policies; provided that any Claims by an Insurer

against a Debtor or the Liquidating Trust shall also be determined under applicable bankruptcy law, and Plan and Confirmation Order provisions.

SECTION 12. CONDITIONS PRECEDENT TO EFFECTIVE DATE

12.1 ***Conditions Precedent to Confirmation of Plan***. The confirmation of the Plan shall be conditioned upon the Bankruptcy Court entering the Confirmation Order in form and substance satisfactory to the Plan Proponents.

12.2 ***Conditions to Effective Date***. The following are conditions precedent to the Effective Date:

(a) The Confirmation Order, including, without limitation, the approval of the Plan Settlement pursuant to Bankruptcy Rule 9019 and § 1123(b)(3)(A), shall have been entered by this Court in form and substance acceptable to the Plan Proponents, which Confirmation Order shall not have been terminated, suspended, vacated or stayed, and shall not have been amended except with the consent of the Plan Proponents;

(b) The SFMC Sale shall have closed;

(c) The Seton Sale shall have closed;

(d) The Debtors have sufficient Cash to satisfy the Debtors' obligations under the Plan to pay or reserve for all Classes of Claims entitled to a Cash payment on, or as of, the Effective Date;

(e) The Debtors have sufficient Cash to fund the Liquidating Trust Reserves; and

(f) All documents, instruments and agreements provided for under or necessary to implement this Plan (including without limitation, the Interim Agreements, the Transition Services Agreements, the Plan Settlement, and the Liquidating Trust Agreement) shall have been executed and delivered by the parties thereto, unless such execution or delivery shall have been waived by the parties benefited thereby.

12.3 ***Waiver of Conditions***. The Plan Proponents may waive the conditions to effectiveness of this Plan, set forth in Section 12.2 hereof, except the condition of paying the Secured Claims as set forth herein, without leave of the Bankruptcy Court and without any formal action other than proceeding with confirmation of this Plan and filing a notice of confirmation with the Bankruptcy Court. To the extent that the Debtors believe that they are unable to comply with the conditions to the effectiveness of this Plan, set forth in Section 12.2 hereof, the Plan Proponents reserve the right to amend the Plan at such time (in accordance with the terms hereof) to address such inability.

SECTION 13. EFFECT OF CONFIRMATION

13.1 ***Vesting of Assets***. Except as provided herein or in the Confirmation Order, upon the Effective Date, pursuant to § 1141(b) and (c), (a) the Liquidating Trust Assets shall vest in the

Liquidating Trust and (b) the Operating Assets shall vest in the Post-Effective Date Debtors, in each case free and clear of all Claims, liens, encumbrances, charges and other interests, subject to the rights and obligations of the parties under this Plan and the Liquidating Trust.

13.2 ***No Discharge.*** Pursuant to § 1141(d), the Debtors will not receive a discharge under this Plan.

13.3 ***Settlement of Causes of Action Relating to Claims***. Unless otherwise authorized by another order of the Bankruptcy Court, pursuant to § 1123(b)(3) and Bankruptcy Rule 9019, and in consideration for the distributions and other benefits provided under the Plan, the provisions of the Plan shall constitute a good faith compromise and settlement of all Causes of Actions relating to the rights that a holder of a Claim may have against the Debtors with respect to any Allowed Claim or any distribution to be made pursuant to the Plan on account of any Allowed Claim. Unless otherwise authorized, the entry of the Confirmation Order shall constitute the Bankruptcy Court's approval, as of the Effective Date, of the compromise or settlement of all such Causes of Action and the Bankruptcy Court's finding that all such Causes of Action are in the best interests of the Debtors, their Estates, their respective property and Claim holders and are fair, equitable and reasonable.

13.4 ***Extension of Existing Injunctions and Stays***. Unless otherwise provided herein, all injunctions or stays arising under §§ 105 or 362, any order entered during the Chapter 11 Cases under §§ 105 or 362 or otherwise, and in existence on the Effective Date, shall remain in full force and effect until the closing of the Chapter 11 Cases.

13.5 ***Releases***.

(a) Releases Of Debtors. As of the Effective Date, for good and valuable consideration, the adequacy of which is hereby confirmed, to the maximum extent permitted by law, each Holder of any Claim shall be deemed to forever release, waive, and discharge all Claims, obligations, suits, judgments, damages, demands, debts, rights, causes of action, and liabilities whatsoever, against the Debtors arising from or related to the Debtors' pre- and/or post-petition actions, omissions or liabilities, transaction, occurrence, or other activity of any nature except for as provided in this Plan or the Confirmation Order.

(b) Settlement Releases. Pursuant to § 1123(b)(3)(A) and the Plan Settlement, as of the Effective Date, for good and valuable consideration, the adequacy of which is hereby confirmed, to the maximum extent permitted by law, each Holder of any Claim shall be deemed to forever release, waive, and discharge all Claims, obligations, suits, judgments, damages, demands, debts, rights, causes of action, and liabilities whatsoever, against the Settlement Released Parties arising from or related to the Settlement Released Parties' pre- and/or post-petition actions, omissions or liabilities, transaction, occurrence, or other activity of any nature except for as provided in this Plan or the Confirmation Order.

(c) Limitation Of Claims Against the Liquidating Trust. As of the Effective Date, except as provided in this Plan or the Confirmation Order, all Persons shall be precluded from asserting against the Liquidating Trust any other or further Claims, obligations, suits, judgments, damages, demands, debts, rights, causes of action, and liabilities whatsoever, relating

to the Debtors or any Interest in the Debtors based upon any acts, omissions or liabilities, transaction, occurrence, or other activity of any nature that occurred prior to the Effective Date.

(d) Debtors' Releases. Pursuant to § 1123(b), and except as otherwise specifically provided in this Plan, for good and valuable consideration, including the service of the Released Parties to facilitate the expeditious liquidation of the Debtors and the consummation of the transactions contemplated by this Plan, on and after the Effective Date, the Released Parties are deemed released and discharged by the Debtors and their Estates from any and all claims, obligations, rights, suits, damages, Causes of Action, remedies, and liabilities whatsoever, including any derivative claims asserted or assertable on behalf of the Debtors, whether known or unknown, foreseen, or unforeseen, existing or herein after arising in law, equity, or otherwise, that the Debtors or their Estates would have been legally entitled to assert in their own right (whether individually or collectively) or on behalf of the Holder of any Claim or other Person, based on or relating to, or in any manner arising from, in whole or in part, the operation of the Debtors prior to or during the Chapter 11 Cases, the transactions or events giving rise to any Claim that is treated in this Plan, the business or contractual arrangements between the Debtors and any Released Party, the restructuring of Claims before or during the Chapter 11 Cases, the marketing and the sale of Assets of the Debtors, the negotiation, formulation, or preparation of this Plan, the Disclosure Statement, or any related agreements, instruments, or other documents, other than a Claim against a Released Party arising out of the gross negligence or willful misconduct of any such person or entity. Claims against any Released Party that are released pursuant to this Section 13.5(d) shall be deemed waived and relinquished by this Plan for purposes of Section 13.9.

(e) ***WAIVER OF LIMITATIONS ON RELEASES. THE LAWS OF SOME STATES (FOR EXAMPLE, CALIFORNIA CIVIL CODE § 1542) PROVIDE, IN WORDS OR SUBSTANCE, THAT A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS/HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS/HER DECISION TO RELEASE. THE RELEASING PARTIES IN SECTIONS 13.5 (a)-(c) OF THE PLAN ARE DEEMED TO HAVE WAIVED ANY RIGHTS THEY MAY HAVE UNDER SUCH STATE LAWS AS WELL AS UNDER ANY OTHER STATUTES OR COMMON LAW PRINCIPLES OF SIMILAR EFFECT.***

13.6 **Injunctions**.

(a) General Injunction. Except as otherwise expressly provided herein, all Persons that have held, currently hold or may hold a Claim against the Debtors are permanently enjoined on and after the Effective Date from taking any action in furtherance of such Claim or any other Cause of Action released and discharged under the Plan, including, without limitation, the following actions against any Released Party: (a) commencing, conducting or continuing in any manner, directly or indirectly, any action or other proceeding with respect to a Claim; (b) enforcing, levying, attaching, collecting or otherwise recovering in any manner or by any means, whether directly or indirectly, any judgment, award, decree or order with respect to a Claim; (c) creating, perfecting or enforcing in any manner, directly or indirectly, any lien or encumbrance of any kind with respect to a Claim; (d) asserting any setoff, right of subrogation or recoupment of any kind, directly or indirectly, against any debt, liability or obligation due to the Debtors, the

Post-Effective Date Debtors or the Liquidating Trust with respect to a Claim; or (e) commencing, conducting or continuing any proceeding that does not conform to or comply with or is contradictory to the provisions of this Plan; provided, however, that nothing in this injunction shall (i) limit the Holder of an Insured Claim from receiving the treatment set forth in Class 9; or (ii) preclude the Holders of Claims against the Debtors from enforcing any obligations of the Debtors, the Post-Effective Date Debtors, the Liquidating Trust, or the Liquidating Trustee under this Plan and the contracts, instruments, releases and other agreements delivered in connection herewith, including, without limitation, the Confirmation Order, or any other order of the Bankruptcy Court in the Chapter 11 Cases. By accepting a distribution made pursuant to this Plan, each Holder of an Allowed Claim shall be deemed to have specifically consented to the injunctions set forth in this Section.

(b) ***Other Injunctions***. ***The Post-Effective Date Debtors, the Liquidating Trustee, the Post-Effective Date Committee, the Post-Effective Date Board of Directors, or the Liquidating Trust and their respective members, directors, officers, agents, attorneys, advisors or employees shall not be liable for actions taken or omitted in its or their capacity as, or on behalf of, the Post-Effective Date Debtors, the Post-Effective Date Board of Directors, the Liquidating Trustee, the Post-Effective Date Committee, or the Liquidating Trust (as applicable), except those acts found by Final Order to arise out of its or their willful misconduct, gross negligence, fraud, and/or criminal conduct, and each shall be entitled to indemnification and reimbursement for fees and expenses in defending any and all of its or their actions or inactions in its or their capacity as, or on behalf of the Post-Effective Date Board of Directors, the Post-Effective Date Debtors, the Liquidating Trustee, the Post-Effective Date Committee, or the Liquidating Trust (as applicable), except for any actions or inactions found by Final Order to involve willful misconduct, gross negligence, fraud, and/or criminal conduct. Any indemnification claim of the Post-Effective Date Debtors, the Post-Effective Date Board of Directors, the Liquidating Trustee, the Post-Effective Date Committee and the other parties entitled to indemnification under this subsection shall be satisfied from either (i) the Liquidating Trust Assets (with respect to all claims, other than those claims related to the Operating Assets), or (ii) the Operating Assets (with respect to all claims related to the Operating Assets). The parties subject to this Section shall be entitled to rely, in good faith, on the advice of retained professionals, if any.***

13.7 ***Exculpation***. To the maximum extent permitted by applicable law, each Released Party shall not have or incur any liability for any act or omission in connection with, related to, or arising out of the Chapter 11 Cases (including, without limitation, the filing of the Chapter 11 Cases), the marketing and the sale of Assets of the Debtors, the Plan and any related documents (including, without limitation, the negotiation and consummation of the Plan, the pursuit of the Effective Date, the administration of the Plan, or the property to be distributed under the Plan), or each Released Party's exercise or discharge of any powers and duties set forth in the Plan, except with respect to the actions found by Final Order to constitute willful misconduct, gross negligence, fraud, or criminal conduct, and, in all respects, each Released Party shall be entitled to rely upon the advice of counsel with respect to their duties and responsibilities under the Plan. Without limitation of the foregoing, each such Released Party shall be released and exculpated from any and all Causes of Action that any Person is entitled to assert in its own right or on behalf of any other Person, based in whole or in part upon any act or omission, transaction, agreement, event or other occurrence in any way relating to the subject matter of this Section.

13.8 ***No Recourse***. If a Claim is Allowed in an amount for which after application of the payment priorities established by this Plan (including, without limitation, in Sections 2 and 4 hereof) there is insufficient value to provide a recovery equal to that received by other Holders of Allowed Claims in the respective Class, no Claim Holder shall have recourse for any such deficiency against any of the Released Parties, the Post-Effective Date Debtors, the Post-Effective Date Board of Directors, the Liquidating Trustee, the Post-Effective Date Committee, or the Liquidating Trust. However, except as specifically stated otherwise in this Plan, nothing in this Plan shall modify any right of a Holder of a Claim under § 502(j). The obligations under this Plan of the Debtors' Estates shall (i) be contractual only and shall not create any fiduciary relationship and (ii) be obligations of the Debtors' Estates only and no individual acting on behalf of the Debtors, the Committee, the Post-Effective Date Debtors, the Post-Effective Date Board of Directors, the Liquidating Trustee, the Post-Effective Date Committee, or otherwise, shall have any personal or direct liability for these obligations. Approval of the Plan by the Confirmation Order shall not in any way limit the foregoing.

13.9 ***Preservation of Causes of Action***.

(a) Except as provided in Section 7.1 hereof, nothing contained in this Plan shall be deemed a waiver or relinquishment of any claims or Causes of Action of the Debtors that are not settled with respect to Allowed Claims or specifically waived or relinquished by this Plan, which shall vest in the Liquidating Trust, subject to any existing valid and perfected security interest or lien in such Causes of Action. The Causes of Action preserved hereunder include, without limitation, claims, rights or other causes of action:

(i) against vendors, suppliers of goods or services (including attorneys, accountants, consultants or other professional service providers), utilities, contract counterparties, and other parties for, including but not limited to: (A) services rendered; (B) over- and under-payments, back charges, duplicate payments, improper holdbacks, deposits, warranties, guarantees, indemnities, setoff or recoupment; (C) failure to fully perform or to condition performance on additional requirements under contracts with any one or more of the Debtors; (D) wrongful or improper termination, suspension of services or supply of goods, or failure to meet other contractual or regulatory obligations; (E) indemnification and/or warranty claims; or (F) turnover causes of action arising under §§ 542 or 543;

(ii) against landlords or lessors, including, without limitation, for erroneous charges, overpayments, returns of security deposits, indemnification, or for environmental claims;

(iii) arising against current or former tenants or lessees, including, without limitation, for non-payment of rent, damages, and holdover proceedings;

(iv) arising from damage to Debtors' property;

(v) relating to claims, rights, or other causes of action the Debtors may have to interplead third parties in actions commenced against any of the Debtors;

(vi) for collection of a debt owed to any of the Debtors;

(vii) against insurance carriers, reinsurance carriers, underwriters or surety bond issuers relating to coverage, indemnity, contribution, reimbursement or other matters;

(viii) relating to pending litigation, including, without limitation, litigation related to the SGM Claims and any other claims or causes of action related thereto, and the suits, administrative proceedings, executions, garnishments, and attachments listed in Attachment 4a to each of the Debtors' Statements of Financial Affairs;

(ix) arising from claims against health plans;

(x) that constitute Avoidance Actions;

(xi) arising under or relating to any and/or all asset purchase agreements and related sale documents (including, without limitation, any leases) entered into during these Chapter 11 Cases, including, but not limited to, enforcement of such agreements by the Debtors' Estates and/or breaches of any and/or all such agreements by the applicable non-Debtor parties (including, without limitation, the purchasers of the Debtors' assets under such agreements and any and all principals and/or guarantors of the obligations under or relating to such agreements);

(xii) all claims against Integrity Healthcare, LLC and BlueMountain Capital Management LLC; and

(xiii) relating to the Operating Assets.

The Liquidating Trustee, the Post-Effective Date Committee, and the Post-Effective Date Debtors shall have, retain, reserve and be entitled to assert all such claims, rights of setoff and other legal or equitable defenses that the Debtors had immediately prior to the Petition Date as fully as if the Chapter 11 Cases had not been commenced, and all of the Debtors' legal and equitable rights respecting any claim that is not specifically waived or relinquished by this Plan may be asserted by the Liquidating Trustee and the Post-Effective Date Committee on their behalf after the Effective Date to the same extent as if the Chapter 11 Cases had not been commenced.

(b) On and after the Effective Date, in accordance with § 1123(b) and the terms of this Plan and the Liquidating Trust Agreement, the Liquidating Trustee shall retain and have the exclusive right to prosecute, abandon, settle or release any or all Causes of Action without the need to obtain approval or further relief from the Bankruptcy Court.

13.10 ***Termination of Responsibilities of the Patient Care Ombudsman***. On the latter of the SFMC Sale Closing Date or the Seton Sale Closing Date, the duties and responsibilities of the Patient Care Ombudsman shall be terminated and the Patient Care Ombudsman shall be discharged from his duties as Patient Care Ombudsman and shall not be required to file any further reports or perform any additional duties as Patient Care Ombudsman. No person or entity may seek discovery in any form, including but not limited to by motion, subpoena, notice of deposition or request or demand for production of documents, from the Patient Care Ombudsman or his agents, professionals, employees, other representatives, designees or assigns (collectively, with the Patient Care Ombudsman, the "***Ombudsman Parties***") with respect to any matters arising from or relating in any way to the performance of the duties of the Patient Care Ombudsman in these Chapter 11 Cases, including, but not limited to, pleadings, reports or other writings filed by the Patient Care Ombudsman in connection with these Chapter 11 Cases. Nothing herein shall in any way limit or otherwise affect the obligations of the Patient Care Ombudsman under confidentiality agreements, if any, between the Patient Care Ombudsman and any other person or entity or shall in any way limit or otherwise affect the Patient Care Ombudsman's obligation, under §§ 332(c) and 333(c)(1) or other applicable law or Bankruptcy Court Orders, to maintain patient information, including patient records, as confidential, and no such information shall be released by the Patient Care Ombudsman without further order of the Bankruptcy Court.

13.11 ***SGM Action***. In the SGM Action, SGM disputes the Debtors' claim to the deposit set forth in the SGM Asset Purchase Agreement (the "***Nonrefundable Deposit***"), and SGM contends that the Nonrefundable Deposit must be returned to SGM. The Debtors and the Plan Proponents dispute the contentions and claims of SGM to the Nonrefundable Deposit, and contend that the Nonrefundable Deposit is an asset of the Debtors' estates, free and clear of any rights or claims of SGM, and should be distributed in accordance with the Plan. On the Effective Date, in accordance with Section 13.1 hereof, all rights of the Debtors against SGM, including, without limitation, all rights to recover the Nonrefundable Deposit, are being transferred to the Liquidating Trust. The Liquidating Trust shall not distribute the Nonrefundable Deposit to creditors in accordance with the Plan or take any other action which would reduce or dissipate the Nonrefundable Deposit, unless permitted by a judgment or an order entered by the District Court having jurisdiction over the SGM Action, and such judgment or order has not been stayed. In the event an appeal is taken from any such judgment or order, the party taking the appeal shall have the right to seek a stay pursuant to the applicable Federal Rules of Civil Procedure and Federal Rules of Appellate Procedure. Nothing contained herein or the Disclosure Statement shall modify, alter or change the rights of the Debtors and the Liquidating Trust, on the one hand, and SGM, on the other hand, to any claim or rights to the Nonrefundable Deposit. All such claims and rights are expressly reserved and preserved.

SECTION 14. RETENTION OF JURISDICTION

14.1 ***Bankruptcy Court Jurisdiction***. Unless otherwise provided herein or in the Confirmation Order, on and after the Effective Date, the Bankruptcy Court shall retain jurisdiction over all matters arising in, arising under, or related to the Chapter 11 Cases. Without limiting the foregoing, the Bankruptcy Court shall retain jurisdiction to:

(a) allow, disallow determine, liquidate, classify, estimate, or establish the priority or secured or unsecured status of any Claim, including the resolution of any request for

payment of any Administrative Claim or Professional Claim and the resolution of any objections to the allowance or priority of Claims, and the resolution of any claim objections brought by the Debtors or by the Liquidating Trustee on behalf of the Liquidating Trust;

(b) resolve any matters related to the assumption, assumption and assignment, or rejection of any Executory Agreement to which a Debtor(s) is a party and to hear, determine and, if necessary, liquidate, any Claims arising from, or cure amounts related to, such assumption or rejection;

(c) determine any motion, adversary proceeding, application, contested matter, and other litigated matter pending on or commenced after the Effective Date, including, without limitation, any and all Causes of Action preserved under the Plan commenced prior to, on, or after the Effective Date;

(d) ensure that distributions to holders of Allowed Claims are accomplished in accordance with the Plan;

(e) hear and determine matters relating to claims with respect to the Debtors' director and officer insurance;

(f) enter, implement or enforce such orders as may be appropriate in the event that the Confirmation Order is for any reason stayed, reversed, revoked, modified, or vacated;

(g) issue injunctions, enter and implement other orders, and take such other actions as may be necessary or appropriate to restrain interference by any Person with the consummation, implementation or enforcement of this Plan, the Confirmation Order or any other order of the Bankruptcy Court, including, without limitation, any actions relating to the Nonprofit Status of the Post-Effective Date Debtors;

(h) resolve a dispute with respect to and/or otherwise appoint a replacement of the Liquidating Trustee, or replacement members of the Post-Effective Date Committee;

(i) hear and determine any application to modify this Plan in accordance with § 1127, to remedy any defect or omission or reconcile any inconsistency in this Plan, the Disclosure Statement, any contract, instrument, release, or other agreement or document created in connection therewith, or any order of the Bankruptcy Court, including the Confirmation Order, in such a manner as may be necessary to carry out the purposes and effects thereof;

(j) hear and determine all applications under §§ 330, 331, and 503(b) for awards of compensation for services rendered and reimbursement of expenses incurred prior to the Effective Date;

(k) hear and determine disputes arising in connection with the interpretation, implementation, obligation or enforcement of this Plan, the Confirmation Order, any transactions or payments contemplated in the Plan, or any agreement, instrument, or other document governing or relating to any of the foregoing;

(l) take any action and issue such orders as may be necessary to construe, enforce, implement, execute and consummate this Plan, including all contracts, instruments, releases, and other agreements or documents created in connection therewith, or to maintain the integrity of this Plan following consummation;

(m) determine such other matters and for such other purposes as may be provided in the Plan and/or the Confirmation Order;

(n) hear and determine matters concerning state, local, and federal taxes in accordance with §§ 346, 505, and 1146, including without limitation, (i) any requests for expedited determinations under § 505(b) filed, or to be filed, with respect to tax returns for any and all taxable periods ending after the Petition Date through, and including, the date of final distribution under the Plan, and (ii) any other matters relating to the Nonprofit Status of the Post-Effective Date Debtors;

(o) hear and determine any other matters related hereto and not inconsistent with the Bankruptcy Code and Title 28 of the United States Code;

(p) authorize recovery of all assets of any of the Debtors and property of the applicable Debtor's Estate, wherever located;

(q) consider any and all claims against each Released Party involving or relating to the administration of the Chapter 11 Cases, any rulings, orders, or decisions in the Chapter 11 Cases or any aspects of the Debtors' Chapter 11 Cases and the events leading up to the commencement of the Chapter 11 Cases, including the decision to commence the Chapter 11 Cases, the development and implementation of the Plan, the decisions and actions taken prior to or during the Chapter 11 Cases and any asserted claims based upon or related to prepetition obligations of the Debtors for the purpose of determining whether such claims belong to the Estates or third parties. In the event it is determined that any such claims belong to third parties, then, subject to any applicable subject matter jurisdiction limitations, the Bankruptcy Court shall have exclusive jurisdiction with respect to any such litigation, subject to any determination by the Bankruptcy Court to abstain and consider whether such litigation should more appropriately proceed in another forum;

(r) hear and resolve any disputes regarding the reserves required hereunder, including without limitation, disputes regarding the amounts of such reserves or the amount, allocation and timing of any releases of such reserved funds; and

(s) enter final decrees closing the Chapter 11 Cases.

SECTION 15. MISCELLANEOUS PROVISIONS

15.1 ***Termination of All Employee, Retiree and Workers' Compensation Benefits***. All existing employee benefits (including, without limitation, workers' compensation benefits, health care plans, disability plans, severance benefit plans, incentive plans, and life insurance plans) and retiree benefits (as such term is defined under § 1114(a)) not previously terminated by the Debtors, or assumed by the Debtors in the Schedule of Assumed Contracts, shall be terminated on or before the Effective Date.

15.2 ***Termination of Collective Bargaining Agreements***. Prior to the Effective Date, the Debtors expect to receive approval for either the consensual or, pursuant to § 1113, the nonconsensual modification, assignment and/or termination of collective bargaining agreements.

15.3 ***Administrative Claims Bar Date.*** All Requests for Payment of an Administrative Claim must be filed with the Bankruptcy Court and served on the Debtors no later than the Administrative Claims Bar Date. Such Requests for Payment may include estimates of amounts through the Effective Date. The Administrative Claims Reserve shall be established on the Effective Date in an amount determined by the Bankruptcy Court in order to satisfy all Administrative Claims that have not been Allowed as of the Effective Date and all Allowed Administrative Claims that will be paid after the Effective Date. In the event that the Debtors, the Liquidating Trustee or the Master Trustee objects to an Administrative Claim, the Bankruptcy Court shall determine the Allowed amount of such Administrative Claim. Notwithstanding the foregoing: (a) no Request for Payment need be filed with respect to an undisputed postpetition obligation which was paid or is payable by the Debtors in the ordinary course of business; provided, however, that in no event shall a postpetition obligation that is contingent or disputed and subject to liquidation through pending or prospective litigation, including, but not limited to, alleged obligations arising from personal injury, property damage, products liability, consumer complaints, employment law (excluding claims arising under workers' compensation law), secondary payor liability, or any other disputed legal or equitable claim based on tort, statute, contract, equity, or common law, be considered to be an obligation which is payable in the ordinary course of business; (b) no Request for Payment need be filed with respect to a cure amount owing under an Executory Agreement if (i) the amount of the cure is fixed or proposed to be fixed by the Confirmation Order or other order of the Bankruptcy Court either pursuant to the Plan or pursuant to a motion to assume and fix the amount of Cure filed by the Debtors, and (ii) a timely objection asserting an increased amount of the cure has been filed by the non-Debtors party to the subject contract or lease; and (c) no Request for Payment need be filed with respect to fees payable pursuant to 28 U.S.C. § 1930. All Administrative Claims that become Allowed after the Effective Date shall be paid solely from the Administrative Claims Reserve , and shall not constitute a claim against the Liquidating Trust, the Liquidating Trustee, or any of the Liquidating Trust Assets. No Holder of an Administrative Claim shall have recourse for any deficiency in the payment of its Administrative Claim against any of the Released Parties, the Post-Effective Date Debtors, the Post-Effective Date Board of Directors, the Liquidating Trustee, the Post-Effective Date Committee, or the Liquidating Trust..

15.4 ***Exemption from Transfer Taxes***. Pursuant to § 1146(c), the assignment or surrender of any lease or sublease, or the delivery of any deed or other instrument of transfer under, in furtherance of, or in connection with, this Plan, including any deeds, bills of sale or assignments executed in connection with any disposition of assets contemplated by this Plan, whether real or personal property, shall not be subject to any stamp, real estate transfer, mortgage recording, sales, use or other similar tax.

15.5 ***Amendments***. The Plan Proponents reserve the right, in accordance with the Bankruptcy Code and the Bankruptcy Rules, to amend or modify this Plan at any time prior to the entry of the Confirmation Order. After the entry of the Confirmation Order, the Plan Proponents may, upon order of the Bankruptcy Court, amend or modify this Plan, in accordance with § 1127(b), or remedy any defect or omission or reconcile any inconsistency in this Plan in such manner as may be necessary to carry out the purpose and intent of this Plan. A holder of an Allowed Claim

that is deemed to have accepted this Plan shall be deemed to have accepted this Plan as modified if the proposed modification does not materially and adversely change the treatment of the Claim of such holder.

15.6 ***Revocation or Withdrawal of Plan***. The Plan Proponents may withdraw or revoke this Plan at any time prior to the Effective Date. If the Plan Proponents revoke or withdraw this Plan prior to the Effective Date, or if the Effective Date does not occur, then this Plan shall be deemed null and void. In such event, nothing contained herein shall be deemed to constitute a waiver or release of any Claim by or against the respective Debtor or any other Person or to prejudice in any manner the rights of the respective Debtor or any other Person in any further proceedings involving the respective Debtor.

15.7 ***Severability***. In the event that the Bankruptcy Court determines, prior to the Effective Date, that any provision of this Plan is invalid, void or unenforceable, the Bankruptcy Court shall, with the Consent of the Plan Proponents, have the power to alter and interpret such term or provision to make it valid or enforceable to the maximum extent practicable, consistently with the original purpose of the term or provision held to be invalid, void or unenforceable, and such term or provision shall then be applicable as altered or interpreted. Notwithstanding any such holding, alteration or interpretation, the remainder of the terms and provisions of this Plan shall remain in full force and effect and shall in no way be affected, impaired or invalidated by such holding, alteration or interpretation. The Confirmation Order shall constitute a judicial determination and shall provide that each term and provision of this Plan, as it may have been altered or interpreted in accordance with the foregoing, is valid and enforceable pursuant to its terms.

15.8 ***Request for Expedited Determination of Taxes***. The Plan Proponents or the Liquidating Trustee, as applicable, shall have the right to request an expedited determination under § 505(b) with respect to tax returns filed, or to be filed, for any and all taxable periods ending after the Petition Date through and including the date of final distribution under the Plan.

15.9 ***U.S. Trustee Quarterly Fees and Post-Confirmation Status Reports.*** All fees payable under 28 U.S.C. § 1930(a)(6) shall be paid by each Debtor in the amounts and at the times such fees may become due up to and including the Effective Date. The Liquidating Trust shall pay all fees payable by each Debtor under 28 U.S.C. § 1930(a)(6) until the Chapter 11 Cases are closed, dismissed or converted; provided, however, that the Sale-Leaseback Debtors shall pay all fees payable under 28 U.S.C. § 1930(a)(6) in their respective Chapter 11 Cases until the expiration of their respective Interim Management Agreements and Interim Leaseback Agreements. Upon the Effective Date, the Liquidating Trust and the Post-Effective Date Debtors shall be relieved from the duty to make the reports and summaries required under Bankruptcy Rule 2015(a). Notwithstanding the foregoing, the Liquidating Trust and Post-Effective Date Debtors shall File and serve the status reports required by Local Bankruptcy Rule 3020-1(b) at such times and for such period as may be set forth in the Confirmation Order.

15.10 ***Courts of Competent Jurisdiction***. If the Bankruptcy Court abstains from exercising, or declines to exercise, jurisdiction or is otherwise without jurisdiction over any matter arising out of this Plan, such abstention, refusal or failure of jurisdiction shall have no effect upon

and shall not control, prohibit or limit the exercise of jurisdiction by any other court having competent jurisdiction with respect to such matter.

15.11 ***Governing Law***. Except to the extent that the Bankruptcy Code or Bankruptcy Rules are applicable, the rights, duties and obligations arising under this Plan shall be governed by, and construed and enforced in accordance with, the laws of the State of California, without giving effect to the principles of conflict of laws thereof.

15.12 ***Continuing Effect of the Bankruptcy Court Orders and Settlement Stipulations***. Unless otherwise set forth in the Plan or the Confirmation Order or otherwise ordered by the Bankruptcy Court, the orders of the Bankruptcy Court and any other settlement stipulations entered into by the Debtors (including without limitation, agreements to lift the automatic stay, resolve litigation claims and limit recoveries to available insurance proceeds) shall not be modified, limited or amended by the Plan and shall remain in full force and effect. To the extent of any direct conflict between the terms of this Plan and any settlement agreements, the conflicting provisions of such settlement agreements shall govern with respect to the treatment of Allowed Claims as provided for therein.

15.13 ***Time***. In computing any period of time prescribed or allowed by this Plan, unless otherwise set forth herein or determined by the Bankruptcy Court, the provisions of Bankruptcy Rule 9006 shall apply. Any reference to "day" or "days" shall mean calendar days, unless otherwise specified herein.

15.14 ***Business Day Transactions***. In the event that any payment or act under this Plan is required to be made or performed on a date that is not a Business Day, then the making of such payment or the performance of such act may be completed on or as soon as reasonably practicable on the next succeeding Business Day, but shall be deemed to have been completed as of the initial due date.

15.15 ***Headings***. Headings are used in this Plan for convenience and reference only and shall not constitute a part of this Plan for any other purpose.

15.16 ***Exhibits***. All Exhibits and schedules to this Plan are incorporated into and are a part of this Plan as if set forth in full herein.

15.17 ***Notices***. Any notices to or requests by parties in interest under or in connection with this Plan shall be in writing and served either by (i) certified mail, return receipt requested, postage prepaid, (ii) hand delivery or (iii) reputable overnight delivery service, all charges prepaid, and shall be deemed to have been given when received by the following parties:

<u>If to the Debtors</u>:

Verity Health System of California, Inc.
601 South Figueroa Street
Suite 4050
Los Angeles, California 90017
Attn: Peter C. Chadwick

with copies to:

Dentons US LLP
Attorneys for the Debtors and Debtors-In-Possession
601 South Figueroa Street
Suite 2500
Los Angeles, California 90017
(213) 623-9300
Attn: Samuel R. Maizel
Tania M. Moyron
Nicholas A. Koffroth

If to the Liquidating Trustee:

[_____]

If to the Master Trustee:

Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
One Financial Center
Boston, Massachusetts 02111
(617) 542-6000
Attn: Daniel S. Bleck
Paul J. Ricotta

If to the Committee:

Milbank LLP
2029 Century Park East
33rd Floor
Los Angeles, California 90067
(424) 386-4000
Attn: Mark Shinderman

If to Verity MOB Financing LLC and
Verity MOB Financing II LLC:

Jones Day
250 Vesey Street
New York, New York 10281
(212) 326-3939
Attn: Bruce Bennett
Benjamin Rosenblum
Peter Saba

15.18 ***Post-Effective Date Notices***. Following the Effective Date, except as otherwise provided herein, notices shall only be served on the Post-Effective Date Debtors, the Liquidating Trustee, the U.S. Trustee, and those Persons who File with the Court and serve upon the Liquidating Trust a request, which includes such Person's name, contact person, address, telephone number, facsimile number, and email, that such Person receive notice of post-Effective Date matters. Persons who had previously filed with the Court requests for special notice of the proceedings and other filings in the Chapter 11 Case shall not receive notice of post-Effective Date matters unless such Persons File a new request in accordance with this Section.

15.19 ***Conflict of Terms.*** In the event of a conflict between the terms of this Plan and the Disclosure Statement, the terms of this Plan shall control.

Dated: Los Angeles, California
As of July 2, 2020

Jeffrey Lewis (SBN 66587)
Margaret Hassleman (SBN 228529)
Catha Worthman (SBN 230399)
Jacob Richards (SBN 273476)
LEWIS, FEINBERG, LEE,
RENAKER & JACKSON, P.C.
476 9th Street
Oakland, CA 94607
Telephone: (510) 839-6824
Facsimile: (510) 839-7839
Email: jlewis@lewisfeinberg.com
mhasselman@lewisfeinberg.com
cworthman@lewisfeinberg.com
jrichards@lewisfeinberg.com

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO/OAKLAND DIVISION

LYNN MORRIS, CAROLINE PLAZA, VERONICA TENCH, JACQUELINE MURRAY, MAIDAFLOR MAYBIR, JOCELYN MANACMUL, DONNA GUTIERREZ, ELEANORE DE DIOS, and ELENITA SANTOS-FUNAI,

Plaintiffs, on behalf of themselves and others similarly situated;

v.

DAUGHTERS OF CHARITY HEALTH SYSTEM, ROBERT ISSAI, STEPHANIE BATTLES, MIKE STUART, DAUGHTERS OF CHARITY MINISTRY SERVICES CORPORATION, DAUGHTERS OF CHARITY OF ST. VINCENT de PAUL, PROVINCE OF THE WEST, and DOES 1-20,

Defendants.

Case No. 14-cv-4681

CLASS ACTION COMPLAINT (ERISA)

1. Plaintiffs Lynn Morris, Caroline Plaza, Veronica Tench, Jacqueline Murray, Maidaflor Maybir, Jocelyn Manacmul, Donna Gutierrez, Eleanore de Dios, and Elenita Santos

-Funai, individually and on behalf of all those similarly situated, as well as on behalf of the Daughters of Charity Health System Retirement Plan (the "the Health System Plan" or "Plan"), as defined herein, by and through their attorneys, hereby allege as follows:

I. INTRODUCTION

2. Plaintiffs work as nurses, housekeepers, and technicians at hospitals owned by the Daughters of Charity Health System ("the Health System"). An important part of their pay includes accrued rights to defined benefit pensions under the Health System Plan. More than 8,800 Health System employees and retirees depend on the benefits the Health System has promised them under the Plan. The pensions the Health System's employees earn are critical to their expected financial support in retirement. However, due to the Health System's violations of the Employee Retirement Income Security Act ("ERISA"), the Plan is short more than $229 million of the funds needed to provide all promised retirement benefits to Plaintiffs and other Plan participants.

3. Following years of worsening financial results, on October 10, 2014, the Health System announced that it would sell its six California hospitals and medical foundation to Prime Healthcare Services and Prime Healthcare Foundation ("Prime" or "Prime Healthcare"). The financially-distressed Plan is among the liabilities the Health System will transfer in this sale. Plaintiffs fear the sale threatens their earned pension benefits. Prime has not committed to operate the Plan as an ERISA-covered Plan, nor has it committed to address the Plan's enormous funding shortfall pursuant to the requirements of ERISA. Prime has also raised the possibility of putting the Health System into bankruptcy, which would further endanger the pensions of Plaintiffs and the other Plan participants.

4. The Plan's precarious situation arises from the Health System's decision to operate the Plan as if it fell within the "Church Plan" exception to ERISA. In so doing, the Health System has failed to comply with many provisions of ERISA designed to protect plan participants, including provisions setting minimum funding standards for defined benefit pension plans.

5. The Health System Plan, however, does not qualify as a Church Plan under the plain language of the statute because the Plan was not established by a church. The Health System thus cannot find shelter from ERISA's funding and fiduciary requirements by erroneously claiming Church Plan status for the Plan.

6. The fact that the Plan is not an ERISA-exempt Church Plan is demonstrated by a recent decision of this Court regarding the status of a similar plan. The U.S. District Court for the Northern District of California has held that the Dignity Health Retirement Plan is governed by ERISA's protections, and is not an exempt Church Plan. *Rollins v. Dignity Health*, --- F. Supp. 2d ---, C13-1450 TEH, 2013 WL 6512682 (N.D. Cal. Dec. 12, 2013), *motion to certify appeal denied*, 13-CV-01450-TEH, 2014 WL 1048637 (N.D. Cal. Mar. 17, 2014). The Court so held because the Dignity Health Retirement Plan was established by Catholic Healthcare West ("CHW"), a multi-hospital health system, which is not a church.

7. As in *Rollins*, the Plan at issue in this case was established by a multi-hospital health system, not by a church. Indeed, the Plan is related to the Dignity Health Retirement Plan at issue in *Rollins*. The Health System was created in 2002 when its six member hospitals spun off from CHW. As part of the transaction, the Health System Retirement Plan spun off from a CHW-sponsored defined benefit retirement plan.

8. Despite its clear status as an ERISA Plan, the Health System has invoked Church Plan status in an attempt to evade the protections to which its current and former employees are entitled. The Health System's failure to treat the Plan as an ERISA plan harms the more than 8,800 Plan participants because the Health System has failed to sufficiently fund the Plan to meet its pension obligations, ignored vital fiduciary duties designed to protect the Plan participants, and engaged in transactions ERISA prohibits. As a result, thousands of employees are at risk of receiving pension payouts that are radically lower than promised. This is exactly the sort of risk that motivated ERISA's passage and that underscores the need for ERISA's protections.

9. Further, in failing to adequately fund the Plan year after year, the Health System has failed to act solely in the interests of Plan participants as ERISA requires of plan fiduciaries. Instead, the Health System has put its own interests above those of Plan participants. The Health

System directly benefits from its failure to adequately fund the Plan and thus has a conflict of interest that prevents it from carrying out its fiduciary duties in a manner consistent with ERISA. This conflict of interest is particularly acute in the context of the ongoing sale of the Health System's hospitals, in which Defendants are proceeding to sacrifice the interests of the Plan participants to the interests of the Health System.

10. Plaintiffs bring this suit in order to protect their rights to their pensions under federal law. Plaintiffs request the Court to declare that the Plan is in fact subject to ERISA's protections. Further, Plaintiffs request that this Court order the Health System and other Defendants to bring the Plan into compliance with ERISA, including ensuring that the Plan is funded in accordance with ERISA's protections; that the Fiduciary Defendants make the Plan whole for any losses and disgorge any profits accumulated as a result of their breaches of fiduciary duty; and that the Fiduciary Defendants pay all applicable civil monetary penalties and provide other appropriate equitable relief, as described further below.

11. Additionally, as a result of the Health System's conflict of interest and its ongoing breach of its fiduciary duties, Plaintiffs seek an order removing the Health System and its executives as Plan fiduciaries. The Court should appoint an independent fiduciary who can protect the interests of Plan participants and carry out his or her duties consistent with ERISA, as also described further below.

II. JURISDICTION AND VENUE

12. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because this is a civil action arising under the laws of the United States, and pursuant to 29 U.S.C. § 1132(e)(1), which provides for federal jurisdiction of actions brought under Title I of ERISA.

13. This Court has personal jurisdiction over Defendant Health System because the Health System is headquartered and transacts business in, and has significant contacts with, this District, and because ERISA provides for nationwide service of process. ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2).

14. This Court has personal jurisdiction over all the Individual Defendants (identified below) because, upon information and belief, they are Officers of the Health System and work in this District and because ERISA provides for nationwide service of process. *Id.*

15. Venue is proper in this District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because (a) the Plan is administered in this District, (b) some or all of the violations of ERISA took place in this District, and/or (c) the Health System may be found in this District.

16. Venue is also proper in this District pursuant to 28 U.S.C. § 1391 because the Health System is headquartered in this District and systematically and continuously does business in this District, and because a substantial part of the events or omissions giving rise to the claims asserted herein occurred within this District.

III. PARTIES

A. Plaintiffs

17. Plaintiff Lynn Morris. Plaintiff Lynn Morris has been an employee of the Health System's St. Francis Medical Center from 1987 to the present. He currently works as a cardiology staff technician. Plaintiff Morris is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) he is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) he has a colorable claim to benefits under the Plan. As such, he is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (c)(3), 29 U.S.C. § 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (c)(3).

18. Plaintiff Caroline Plaza. Plaintiff Caroline Plaza has been an employee of the Health System's St. Francis Medical Center from 1995 to the present. She currently works as a trauma department assistant. Plaintiff Plaza is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to

ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (c)(3), 29 U.S.C. § 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (c)(3).

19. Plaintiff Veronica Tench. Plaintiff Veronica Tench has been an employee of the Health System's St. Vincent Medical Center from 1980 to the present. She currently works as a phlebotomist and lab assistant. Plaintiff Tench is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. § 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

20. Plaintiff Jacqueline Murray. Plaintiff Jacqueline Murray has been an employee of the Health System's St. Francis Medical Center from 1989 to the present. She currently works as a registered nurse in the neonatal intensive care unit. Plaintiff Murray is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

21. Plaintiff Maidaflor Maybir. Plaintiff Maidaflor Maybir has been an employee of the Health System's St. Francis Medical Center from 1990 to the present. She currently works as a recovery room registered nurse. Plaintiff Maybir is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

22. Plaintiff Jocelyn Manacmul. Plaintiff Jocelyn Manacmul has been an employee of the Health System's St. Francis Medical Center from 1982 to the present. She currently

works as a registered nurse in the intensive care unit. Plaintiff Manacmul is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

23. Plaintiff Donna Gutierrez. Plaintiff Donna Gutierrez has been an employee of the Health System's St. Francis Medical Center from 1983 to the present. She currently works as an operating room registered nurse. Plaintiff Gutierrez is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

24. Plaintiff Eleanore de Dios. Plaintiff Eleanore de Dios has been an employee of the Health System's St. Francis Medical Center from 1982 to the present. She currently works as a registered nurse in the intensive care unit. Plaintiff de Dios is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

25. Plaintiff Elenita Santos-Funai. Plaintiff Elenita Santos-Funai has been an employee of the Health System's St. Francis Medical Center from 1999 to the present. She currently works as a registered nurse in the surgery center. Plaintiff Santos-Funai is a participant in the Plan within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7), because (1) she is eligible to receive pension benefits under the Plan to be paid at normal retirement age, or (2) she has a colorable claim to benefits under the Plan. As such, she is entitled to maintain an

action with respect to the Plan pursuant to ERISA §§ 502(a)(1)(A), (a)(2), (a)(3), and (c)(1) and (3), 29 U.S.C. §§ 1132(a)(1)(A) and (B), (a)(2), (a)(3), and (c)(1) and (3).

B. Fiduciary Defendants

26. Defendant Health System. The Health System is a 501(c)(3) non-profit corporation organized under, and governed by, California's Nonprofit Corporation Law, California Corporations Code §§ 5000 *et seq*. The Health System is headquartered in Los Altos Hills, California. At all relevant times, the Health System has been the sponsor of the Plan within the meaning of ERISA § 3(16)(B), 29 U.S.C. § 1002(16)(B). At all relevant times, the Health System also has been the Administrator of the Plan within the meaning of ERISA § 3(16)(A), 29 U.S.C. § 1002(16)(A), because it has been designated as such in the governing written instrument of the Plan or has been the plan sponsor. At all relevant times, Defendant Health System also has been a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A), because it has exercised discretionary authority and/or control regarding the management of the Plan, exercised authority or control respecting management or disposition of its assets, or has had discretionary authority or discretionary responsibility in the administration of the Plan. Defendant Health System at all relevant times also has been a party in interest under ERISA § 3(14), 29 U.S.C. § 1002(14) both because it is a fiduciary and because it is an employer whose employees are covered by the Plan.

27. Defendant Robert Issai. Defendant Robert Issai is the President and Chief Executive Officer of the Health System. On information and belief, in this role Defendant Issai carries out some or all of the Health System's fiduciary functions with respect to the Plan. As such, he exercises discretionary authority with regard to the administration of the Plan and/or its assets and is therefore a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

28. Defendant Stephanie Battles. Defendant Stephanie Battles is the Health System's Vice President of Human Resources. On information and belief, in this role Defendant Battles carries out some or all of the Health System's fiduciary functions with respect to the Plan. As such, she exercises discretionary authority with regard to the

administration of the Plan and/or its assets and is therefore a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

29. Defendant Mike Stuart. Defendant Mike Stuart is Chief Financial Officer of the Health System. On information and belief, in this role Defendant Stuart carries out some or all of the Health System's fiduciary functions with respect to the Plan. As such, he exercises discretionary authority with regard to the administration of the Plan and/or its assets and is a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

30. Defendants John and Jane Does 1-20. Defendants John and Jane Does 1-20 are individuals who through discovery are found to have fiduciary responsibilities with respect to the Plan and are fiduciaries within the meaning of ERISA. These individuals will be added by name as defendants in this action upon motion by Plaintiffs at an appropriate time.

31. Defendants Issai, Battles, Stuart, and John and Jane Does 1-20 are referred to herein collectively as the "Individual Defendants."

32. Defendant Health System, Issai, Battles, Stuart, and John and Jane Does 1-20 are referred to herein collectively as the "Fiduciary Defendants."

C. Controlled Group Defendants

33. Defendant Daughters of Charity Ministry Services Corporation. Defendant Daughters of Charity Ministry Services Corporation (the "Ministry Services Corporation") is a 501(c)(3) non-profit corporation organized under, and governed by, California's Nonprofit Corporation Law, California Corporations Code §§ 5000 *et seq*. The Ministry Services Corporation is headquartered in Los Altos Hills, California. The Health System Articles of Incorporation provide that the Ministry Services Corporation is the sole corporate member of the Health System. As such, under California Corporations Code § 5056, the Ministry Services Corporation has the power to appoint directors to the Health System board and to approve the disposition of all or substantially all of the assets of the Health System. Accordingly, Ministry Services Corporation is a member of the same controlled group as the Health System for purposes of ERISA § 302(b)(2), 29 U.S.C. § 1082(b)(2).

34. Defendant Daughters of Charity of St. Vincent de Paul, Province of the West. On information and belief, Defendant Daughters of Charity of St. Vincent de Paul, Province of the West ("the Province") is a 501(c)(3) non-profit corporation organized under, and governed by, the California's Nonprofit Corporation Law, California Corporations Code §§ 5000 *et seq*. The Province is headquartered in Los Altos Hills, California. Six of the eight members of the Health System board of directors are members of the Province. The members and directors of the Ministry Services Corporation are members of the Province. Accordingly, the Province is a member of the same controlled as the Health System group for purposes of ERISA § 302(b)(2), 29 U.S.C. § 1082(b)(2).

IV. FACTUAL ALLEGATIONS

A. The Health System's Operations

35. Defendant Health System is a California not-for-profit religious corporation organized under, and governed by, California's Nonprofit Corporation Law, California Corporations Code §§ 5000 *et seq***.**

36. The Health System has six member hospitals: O'Connor Hospital in San Jose, California; St. Louise Regional Hospital in Gilroy, California; Seton Medical Center in Daly City, California; Seton Coastside in Moss Beach, California; St. Francis Medical Center in Lynwood, California; and St. Vincent Medical Center in Los Angeles, California.

37. Until 1995, the Health System member hospitals were part of the Daughters of Charity National Health System ("DCNHS"), which was established in 1986. In 1995, the six hospitals spun off from DCNHS and merged into CHW. In 2001 and 2002, the six hospitals withdrew from CHW, and reincorporated as the Health System.

38. The Health System does not claim to be and is not a church. The Health System operates like any other nonprofit multi-hospital health system.

39. Like other non-profit multi-hospital health systems, the Health System relies upon revenue bonds to raise money, and it has significant sums invested in, among other things, equity securities, mortgage-backed securities, fixed-income securities, and hedge funds.

40. The Health System employs more than 7,500 individuals.

41. The Health System specifically does not limit employment to those of the Catholic faith, instead hiring employees without any reference to creed or religion.

42. The management of the Health System is composed primarily of lay people, and Executive Officers of the Health System receive compensation in line with executive officers of other hospital systems. At least ten officers or key employees received reportable compensation in excess of half a million dollars in 2013.

43. The Health System offers a defined benefit plan to certain employees, the Retirement Plan for Hospital Employees ("RPHE"), which it administers as an ERISA plan. The RPHE is a multi-employer plan under ERISA § 3(37), 29 U.S.C. § 1002(37). In addition to the Health System, there are several other non-profit multi-hospital health systems and health organizations that are participating employers in the RPHE. The claims in this complaint do not pertain to the RPHE.

44. The Health System also sponsors a health benefit plan for its employees that it operates as an ERISA-covered plan. The Health System Medical Foundation, a subsidiary of the Health System, also maintains an ERISA plan to provide health benefits for its employees.

45. The sponsoring order of the Health System, the Daughters of Charity of St. Vincent DePaul Province of the West, maintains an ERISA retirement plan for its employees.

46. Through its Medical Foundation, the Health System has acquired numerous clinics, physician groups, and individual physician practices throughout California. As of April 2014, the Foundation included 28 clinic sites, 164 staff physicians, and 89 physicians aligned through an independent practice association. Many of these have no religious affiliation. Additionally, many of these provide medical services that contradict the teachings of the Catholic Church, including contraceptives and sterilization procedures.

47. The Health System also collaborates with medical institutions that claim no religious affiliation of any kind, such as Stanford University.

48. The Health System does not impose its beliefs or religious practices on its patients. In fact, the Health System employs chaplains of non-Catholic faiths and offers contact with the minister, priest, rabbi, or spiritual leader of its patients' choosing.

49. The Health System owns a captive insurance company, Marillac Insurance Company, Ltd., incorporated in the Cayman Islands.

50. The Health System purports to disclose, and not keep confidential, its own financial records. For example, the Health System is required and in some cases has voluntarily elected to comply with a broad array of elaborate state and federal regulations and reporting requirements, including Medicare and Medicaid. In addition, the Health System makes public its consolidated financial statements, which describe the Health System's representations as to its own operations and financial affairs. The Health System also files an annual Form 990 with the Internal Revenue Service, disclosing various financial matters. Moreover, the Health System operates the Plan as a tax-qualified Plan, and accordingly provides substantial financial and other information to the IRS, while nonetheless failing to provide similar information to the Department of Labor because the Plan claims to be exempt from ERISA. Finally, the Health System regularly discloses financial information to the rating agencies and to the public when it issues tax exempt revenue bonds.

B. The Health System Plan

51. The Health System maintains the Plan, which is a defined benefit pension plan covering the Health System employees at member hospitals St. Francis Medical Center and St. Vincent Medical Center, as well as at the Health System's central system office.

52. As a defined benefit plan, the Plan's standard form of benefit is a monthly payment to participants upon retirement. The monthly benefit amount is calculated using a formula that takes into account factors including the participant's earnings prior to retirement and years of service.

//

//

//

1. The Health System Retirement Plan Is Not a Church Plan.

a. Only Two Types of Plans Qualify as a Church Plan, and The Plan Is Neither.

53. Under section 3(33) of ERISA, 29 U.S.C. § 1002(33), in order to qualify for the Church Plan exception, a plan must be established by a church. Thus, only the following two types of plans may qualify as a Church Plan:

- First, under section 3(33)(A) of ERISA, 29 U.S.C. § 1002(33)(A), a plan *established and maintained* by a church or convention or association of churches, can qualify under certain circumstances and subject to the restrictions of § 3(33)(B) of ERISA, 29 U.S.C. § 1002(33)(B); and
- Second, under section 3(33)(C)(i) of ERISA, 29 U.S.C. § 1002(33)(C)(i), a plan can qualify if it is both:
  - *established* by a church or by a convention or association of churches **and**
  - *maintained* by an organization, *the principal purpose or function of which is the administration or funding of a retirement plan*, if such organization is controlled by or associated with a church or convention or association of churches, can qualify under certain circumstances and subject to the restrictions of § 3(33)(B) of ERISA, 29 U.S.C. § 1002(33)(B).

54. Thus, under both tests, a plan must be "established" by a church or by a convention or association of churches in order to qualify as a "Church Plan." If the "establish" element is not met, as it is not here, then the Plan cannot qualify as a "Church Plan" under either version of the Church Plan exemption.

55. Here, the Plan was "established" by the Health System or one of its predecessor hospital systems, not by a church or convention or association of churches. Therefore, the Plan is not a Church Plan under ERISA § 3(33)(A), 29 U.S.C. § 1002(33)(A).

56. Additionally, under both tests a second element must be met before a plan is exempt ERISA's requirements. The plan must be maintained either directly by the church (ERISA § (33)(A), 29 U.S.C. § 1002(33)(A)), or by an organization that is controlled by the church and that has the principal purpose of maintaining the plan (§ 3(33)(C)(i) of ERISA, 29

U.S.C. § 1002(33)(C)(i)). If the "maintain" element is not met, as it is not here, then the Plan does not meet either version of the church exemption.

57. The Plan is not maintained for employees of any church or convention or association of churches. It is maintained for the employees of the Health System. This is another reason that the Plan is not a Church Plan as defined in ERISA § 3(33)(A), 29 U.S.C § 1002(33)(A).

58. The Plan also does not qualify as a "Church Plan" under § 3(33)(C)(i) because it is maintained by the Health System. The principal purpose or function of the Health System is not the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both. . The principal purpose of the Health System is to own and operate hospitals and healthcare related entities. The Plan thus cannot qualify as a Church Plan under ERISA § 3(33)(C)(i), 29 U.S.C § 1002(33)(C)(i).

b. Under the Ruling of this Court in *Rollins v. Dignity Health*, the Health System Retirement Plan Is Not a Church Plan.

59. This Court recently found that the Dignity Health Retirement Plan, a retirement plan similar to the Plan at issue here, is not a Church Plan because it was established by CHW, Dignity's predecessor hospital system. *Rollins*, 2013 WL 6512682, at *7. The Court further held that "whether or not the Sponsoring Congregations controlled CHW is immaterial because CHW was a separate corporation at the time it established the Plan." *Rollins*, 2014 WL 3613096 at *4 (N.D. Cal. July 22, 2014). The determinative fact in *Rollins* was that CHW was not a church.

60. *Rollins* shows that the Plan at issue here, like the Dignity Plan, does not meet the statutory definition of a Church Plan, and thus must conform to the requirements of ERISA. The Health System Plan was established by the Health System and/or one or more of the Health System's predecessors. Like CHW, the Health System and its predecessors are hospital systems, not churches, nor are they conventions or associations of churches.

61. Further, the Plan is related to the Dignity Health retirement plan and to CHW. When the Health System member hospitals were part of CHW (*see* paragraph 37, above), CHW

and its affiliates maintained one or more retirement plans that covered employees of the Health System's hospitals.

62. In 2002, the Health System took its present form after a spin off from CHW. At that time, the Health System, its member hospitals, CHW, and several regional CHW affiliates entered into a Benefits and Employment Transition Agreement ("Transition Agreement") regarding employee benefits for the workers who would become Health System employees after the transition. The Transition Agreement provided that the Health System and its affiliates would continue to provide retirement plans to the hospitals' employees with benefits substantially equivalent to the benefits CHW had been providing. As part of the Transition Agreement, the Health System agreed to "adopt and assume sponsorship of and liability for" two specified CHW retirement plans that covered employees of the Health System member hospitals.

63. The Health System currently operates the Plan as though it were a Church Plan under ERISA § 3(33), 29 U.S.C. § 1002(33), and the analogous section of the Internal Revenue Code ("IRC"). Therefore, the Health System operates the plan as if it is exempt from ERISA's coverage under ERISA § 4(b)(2), 29 U.S.C. § 1003(b)(2). It is not. In fact, the Plan is governed by ERISA's protections.

2. The Health System Plan Is a Defined Benefit Pension Plan Within the Meaning of ERISA.

64. The Plan is a plan, fund, or program that was established or maintained by an employer and which by its express terms and surrounding circumstances provides retirement income to employees and/or results in the deferral of income by employees to the termination of their employment or beyond. As such, the Plan is an "employee pension benefit plan" within the meaning of ERISA § 3(2)(A), 29 U.S.C§ 1002(2)(A).

65. The Plan does not provide for an individual account for each participant and does not provide benefits based solely upon the amount contributed on a participant's account. As such, the Plan is a defined benefit plan within the meaning of ERISA § 3(35), 29 U.S.C. § 1002(35), rather than an individual account plan or a "defined contribution plan" within the meaning of ERISA § 3(34), 29 U.S.C. § 1002(34).

3. The Plan Fiduciaries Have Breached Their Duties to Ensure That the Plan Is Fully Funded in Accord with ERISA.

66. Under ERISA, the Plan must have an annual actuarial report assessing the plan's funding needs. ERISA § 103(d), 29 U.S. C. § 1023(d). The Plan is further required each and every year to follow a funding plan that meets the funding standards of ERISA and is based on reasonable actuarial assumptions. ERISA §§ 302, 303, 29 U.S.C. §§ 1082, 1083.

67. The Health System is responsible for setting the funding requirements of the Plan, as well as setting a funding policy for the Plan. The Plan document states that the Health System "will periodically cause the short-run and long-run financial needs of the Plan to be determined and communicated to the Trustee." The Plan document also provides that based on these needs and appropriate actuarial evaluations, the Health System "will establish a funding policy and method consistent with the objectives of the Plan and the Participating Employers will make contributions to the Trust in such amounts and at such times as may be required by such funding policy."

68. Defendant Health System has failed to set a funding policy that would adequately fund the anticipated obligations of the Plan every year since at least approximately 2010.

69. As of December 31, 2013, the Plan was underfunded by more than $229 million.

70. On information and belief, the Plan is even more severely underfunded today.

71. In 2012, Defendant Health System adopted a funding policy that amortized over ten years the unfunded liability as of January 1, 2012, and required the Health System to make payments accordingly. By that point, the Plan was already underfunded by millions of dollars.

72. By adopting a funding policy that amortized over ten years the significant unfunded liabilities of the plan, Defendant Health System made the decision not to address the Plan's severe underfunding in a timely fashion, instead endangering the retirement security of approximately 8,800 Plan participants.

73. By putting off the date by which the Plan was expected to ensure the minimum funding necessary to cover the Plan's liabilities, the Health System betrayed the Plan participants who rely on the Plan for a secure income in retirement. In setting a

funding policy that was so profoundly inadequate, the Health System breached its duty as a plan fiduciary to administer the plan prudently and in the best interests of Plan participants and beneficiaries, as alleged further below.

74. Defendants Issai, Battles, and Stuart are also responsible for the decisions to underfund the Plan. As Plan fiduciaries and Health System executives, Defendants Issai, Battles, and Stuart were involved in each annual decision to set a funding policy that was inadequate to meet the Plan's liabilities.

75. In the alternative, Defendants Issai, Battles, and Stuart are liable as co-fiduciaries for underfunding the Plan because they knew of the Health System's actions in failing to provide adequate plan funding, and failed to take steps to address the Health System's breach of fiduciary duty.

76. In continuing to set an inadequate funding policy year after year, and in following such policies in a way that resulted in underfunding the Plan by hundreds of millions of dollars, the Fiduciary Defendants have breached their fiduciary duties of prudence and loyalty.

4. The Plan Fiduciaries Have a Conflict of Interest that Requires They Be Replaced with an Independent Fiduciary.

77. In continuing to set an inadequate funding policy each year, and in following that policy to underfund the Plan by hundreds of millions of dollars, the Health System has acted at all times in its own interest, and has not acted solely in the interests of Plan participants, as is required of the Health System as a fiduciary of an ERISA plan. The Health System benefits from its decision not to adequately fund the Plan, and thus has a conflict of interest that prevents it from carrying out its fiduciary duties in a manner consistent with ERISA.

78. This conflict of interest extends to the Individual Defendants. They have at all times acted in the interests of the Health System, and not solely in the interests of Plan participants, as is required of them as ERISA fiduciaries.

79. Despite this conflict of interest, the Health System and the Individual Defendants have failed to appoint an independent fiduciary who could carry out his or her duties to protect Plan participants in a manner consistent with ERISA, or to take other appropriate steps to address the conflict.

80. As a result of the Fiduciary Defendants' conflict of interest, and in light of their repeated and ongoing breaches of their fiduciary duties, it is necessary for the Court to appoint an independent fiduciary who can protect the interests of Plan participants and carry out his or her duties consistent with ERISA.

C. The Health System's Financial Difficulties and Impending Sale

81. In recent years, the Health System has experienced increasing financial difficulties, with operating losses growing over at least the past three years. The Health System has experienced a declining volume of patients and decreasing revenues since at least 2009. In the fiscal year ending June 30, 2013, the Health System had an operating loss of $107 million. This is considerably worse than the prior fiscal year, which had ended with an $82 million operating loss.

82. In April 2014, Standard & Poor's calculated that the Health System's operating loss from only the first half of fiscal year 2014 would be $92.8 million. Absent a one-time June 30, 2014 donation from the Daughters of Charity Foundation, the Health System would have ended fiscal year 2014 with an operating loss of over $145 million.

83. These financial difficulties have eroded the Health System's unrestricted reserves to a concerning level. As of December 31, 2013, the Health System had only 36 days' worth of cash on hand. The Health System is currently insolvent.

84. In April 2014, Standard & Poor's downgraded the credit rating for some or all of the Health System's outstanding bonds from B- to BBB-. Standard & Poor's expressed the opinion that the Health System's "balance sheet offers very limited cushion for further prolonged losses."

85. The Health System had $294.2 million in outstanding long-term debt as of December 31, 2013.

86. In 2012 and 2013, the Health System explored the possibility of merging with Ascension Health Alliance. In January 2014, however, the Health System announced that no such merger would occur.

87. Instead, in January 2014, the Health System announced that it would begin to solicit proposals from potential buyers for the entire hospital system or the individual hospitals. The Health System indicated that it would consider proposals from all buyers, regardless of religious affiliation.

88. On October 10, 2014, the Health System announced that it had selected Ontario, California-based Prime Healthcare to purchase the Health System hospitals, pending approval of the California Attorney General. Prime is a private, non-religious, for-profit corporation that currently operates 28 acute care hospitals in eight states.

89. To date, Prime has provided no commitment to operate the Plan in conformity with the requirements of ERISA, nor has it identified a strategy to address the massive underfunding of the Plan.

90. In light of the impending sale of the Health System hospitals to Prime, the Fiduciary Defendants' conflict of interest is particularly acute, as they pursue the sale of the Health System in a way that puts the interests of the Health System before the interests of the Plan participants.

91. This ongoing conflict makes the appointment of an independent fiduciary even more urgent, as the current Plan fiduciaries are unable or unwilling to fulfill their duties to Plan participants as the sale of the Health System hospitals proceeds. Without an independent fiduciary, Plan participants will be left with no one to protect their interests through the sale process.

V. CLASS ALLEGATIONS

92. Plaintiffs bring this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of themselves and the following class of persons similarly situated: All participants in and beneficiaries of the Health System Retirement Plan. Excluded

from the Class are the Individual Defendants and any individuals who are subsequently determined to be fiduciaries of the Plan.

A. Numerosity

93. The exact number of Class members is unknown to Plaintiffs at this time, but may be readily determined from records maintained by the Health System. On information and belief, there are approximately 8,800 participants in the Plan.

B. Commonality

94. The issues regarding liability present common questions of law and fact with answers that are common to all members of the Class, including, but not necessarily limited to the following: (1) whether the Plan is covered by ERISA or is exempt from ERISA as a Church Plan; (2) whether the Plan administrator failed to comply with ERISA's reporting and disclosure provisions; (3) whether the Fiduciary Defendants have failed to establish a funding policy in compliance with ERISA and have failed to take action to collect the contributions that the Health System would owe under those standards; (4) whether the Fiduciary Defendants breached their fiduciary duties in failing to comply with various provisions of ERISA; and (5) whether the Fiduciary Defendants caused the Plan to engage in prohibited transactions in violation of ERISA § 406, 29 U.S.C. § 1106.

95. The issues regarding relief are also common to the members of the Class because the requested relief consists of: (1) a declaration that the Plan is an ERISA-covered plan; (2) an order requiring that the Defendant Fiduciaries comply with their duties under ERISA, including but not limited to establishing and enforcing a funding policy in compliance with ERISA's standards; (3) an order requiring the Health System to pay civil penalties to the Class, in the same statutory daily amount for each member of the Class; (4) an order requiring Defendants to make whole the losses suffered by the Plan due to violations of ERISA; (5) an order removing Defendant Fiduciaries as such and replacing them with an Independent Fiduciary; and (6) ordering such other equitable remedies as may be appropriate.

//

//

C. Typicality

96. Plaintiffs' claims are typical of the claims of the other members of the Class because their claims arise from the same event, practice and/or course of conduct, namely Defendants' failure to operate the Plan as an ERISA-governed plan subject to funding standards, reporting requirements, and fiduciary duties. Plaintiffs' claims are also typical because all Class members are similarly, if not identically, affected by Defendants' wrongful conduct.

97. Plaintiffs' claims are also typical of the claims of the other members of the Class because, to the extent Plaintiffs seek equitable or other relief, it will affect all Class members equally.

98. Defendants do not have any defenses unique to the Plaintiffs' claims that would make the Plaintiffs' claims atypical of the remainder of the Class.

D. Adequacy

99. Plaintiffs will fairly and adequately represent and protect the interests of all members of the Class.

100. Plaintiffs do not have any interests antagonistic to or in conflict with the interests of the Class.

101. Defendants have no unique defenses against Plaintiffs that would interfere with the Plaintiffs' representation of the Class.

102. Plaintiffs have engaged counsel with extensive experience prosecuting class actions in general and ERISA class actions in particular.

E. Rule 23(b)(1) Requirements

103. The requirements of Rule 23(b)(1)(A) are satisfied because prosecution of separate actions by the members of the Class would create a risk of establishing incompatible standards of conduct for Defendants. Simply put, any adjudication about the status of the Plan under ERISA and about Defendants' duties to the Plan will require that the Defendants operate the Plan in a similar, if not identical, manner for all class members.

104. The requirements of Rule 23(b)(1)(B) are satisfied because adjudications of these claims by individual members of the Class would, as a practical matter, be dispositive of the interests of the other members not parties to the action, or substantially impair or impede the ability of other members of the Class to protect their interests. Simply put, any adjudication about the Plan and about Defendants' duties to the Plan will apply to the Plan and be applicable to all class members.

F. Rule 23(b)(2) Requirements

105. Class action status is also warranted under Rule 23(b)(2) because Defendants have acted or refused to act on grounds generally applicable to the Class, thereby making appropriate final injunctive, declaratory, or other appropriate equitable relief with respect to the Class as a whole. Simply put, Defendants' operation of the Plan as a purported Church Plan has been applicable to all Class Members, and any adjudication about the Plan and about Defendants' duties to the Plan, and any injunctive, declaratory, or other appropriate equitable relief, will apply to all class members.

G. Rule 23(b)(3) Requirements

106. In the alternative to certification under Rule 23(b)(1) and/or (b)(2), class action status is also warranted under Rule 23(b)(3) because the class-wide issues of the status of the Plan and the resulting duties under ERISA predominate over any individual issues, and because a class action is superior to other methods to fairly and efficiently adjudicate these issues.

VI. CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

Declaratory and Equitable Relief Against All Defendants
(Declaratory Judgment Act and ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3))

107. Plaintiffs repeat and re-allege the allegations contained in all foregoing paragraphs herein.

108. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a participant or beneficiary to bring a civil action to "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief

(i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

109. Pursuant to this provision, 28 U.S.C. §§ 2201 and 2202, and Federal Rule of Civil Procedure 57, Plaintiffs seek declaratory relief that the Plan is not a Church Plan within the meaning of ERISA § 3(33), 29 U.S.C. § 1002(33), and thus is subject to the provisions of Title I and Title IV of ERISA.

110. Plaintiffs further seek orders directing all Defendants to bring the Plan into compliance with ERISA, including the reporting and funding requirements of Parts 1, 2 and 3 of Title I of ERISA, 29 U.S.C. §§ 1021-31, 1051-61, 1081-85, and by remedying the additional violations set forth below.

111. Additionally, Plaintiffs seek an order that the Health System and the other defendants make all contributions to the Plan necessary to remedy the Plan's funding shortfall.

SECOND CLAIM FOR RELIEF

Violation of Reporting and Disclosure Provisions Against Defendant Health System (ERISA §§ 101-105, 502(a)(1)(A),(a)(3), 29 U.S.C. §§ 1021-1025, 1132(a)(1)(A),(a)(3))

112. Plaintiffs incorporate and re-allege by reference the foregoing paragraphs as if fully set forth herein.

113. ERISA § 502(a)(1)(A), 29 U.S.C. § 1132(a)(1)(A), permits a plan participant to bring suit for penalties where a defendant violates the recordkeeping obligations set forth in ERISA.

114. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), permits a plan participant to bring a suit to obtain appropriate equitable relief to enforce the provisions of Title I of ERISA or to enforce the terms of a plan.

A. Summary Plan Descriptions

115. Under ERISA §§ 102 and 104, 29 U.S.C. §§ 1022 and 1024, employee benefit plans are required to provide Summary Plan Descriptions to participants and beneficiaries. Such Summary Plan Descriptions must include certain specified information, including the name and type of administration of the plan; the name and address of the administrator,

trustees, and the agent for service of legal process; an explanation of the plan's requirements respecting eligibility and participation and benefits; the remedies available for redress of denied claims; and a statement of participants and beneficiaries' rights under ERISA. *Id.*; 29 C.F.R. § 2520.102–3.

116. In every year since at least 2002, the Health System has failed to provide Plaintiffs or any other Plan participants with a Summary Plan Description that meets the requirements of ERISA § 102, 29 U.S.C. § 1022, and the regulations promulgated thereunder.

117. Because the Health System has been the Administrator of the Plan at all relevant times, it violated ERISA §§ 102 and 104, 29 U.S.C. §§ 1022 and 1024, by failing to provide Plaintiffs and members of the Class with Summary Plan Descriptions complying with ERISA's requirements.

B. Annual Reports

118. Under ERISA § 103, 29 U.S.C. § 1023, employee benefit plans are required to file an annual report with the Secretary of Labor. This report, submitted via a Form 5500, must include certain specified information about the plan's finances, participants, and administration.

119. In every year since at least 2002, the Health System has failed to file an annual report with respect to the Plan with the Secretary of Labor in compliance with ERISA § 103, 29 U.S.C. § 1023, or a Form 5500 and associated schedules and attachments which the Secretary has approved as an alternative method of compliance with ERISA § 103, 29 U.S.C. § 1023.

120. Because the Health System has been the Administrator of the Plan at all relevant times, the Health System has violated ERISA § 104(a), 29 U.S.C. § 1024(a), by failing to file annual reports with respect to the Plan with the Secretary of Labor in compliance with ERISA § 103, 29 U.S.C. § 1023, or Form 5500s and associated schedules and attachments that the Secretary has approved as an alternate method of compliance with ERISA § 103, 29 U.S.C. § 1023.

//

C. Summary Annual Reports

121. Under ERISA § 104(b)(3), 29 U.S.C. § 1024(b)(3), administrators of employee benefit plans are required to provide participants and beneficiaries with summary annual reports containing certain specified financial information, including a statement of plan assets and liabilities and a schedule of all transactions involving persons known to be a party in interest.

122. In every year since at least 2002, the Health System has failed to furnish Plaintiffs or any member of the Class with a Summary Annual Report with respect to the Plan in compliance with ERISA § 104(b)(3), 29 U.S.C. § 1024(b)(3), and regulations promulgated thereunder.

123. Because the Health System has been the Administrator of the Plan at all relevant times, the Health System has violated ERISA § 104(b)(3), 29 U.S.C. § 1024(b)(3), by failing to furnish Plaintiffs or any member of the Class with a Summary Annual Report with respect to the Plan in compliance with ERISA § 104(b)(3), 29 U.S.C. § 1024(b)(3), and regulations promulgated thereunder.

D. Notification of Failure to Meet Minimum Funding Standards

124. Under ERISA § 101(d)(1), 29 U.S.C. § 1021(d)(1), employers maintaining employee benefit plans are required to issue to participants and beneficiaries a notice whenever the plan fails to make a required installment or other payment required to meet the minimum funding standards under ERISA.

125. At all relevant times, Defendant Health System has been the employer that established and/or maintained the Plan.

126. Since at least 2002, Defendant Health System has failed to fund the Plan in accordance with ERISA § 302, 29 U.S.C. § 1082.

127. At no time has the Health System furnished Plaintiffs or any member of the Class with a Notice with respect to the Plan pursuant to ERISA § 101(d)(1), 29 U.S.C. § 1021(d)(1), informing them that the Health System had failed to make payments required to comply with ERISA § 302, 29 U.S.C. § 1082, with respect to the Plan.

//

E. Funding Notices

128. Under ERISA § 101(f), 29 U.S.C. § 1021(f), administrators of defined benefit plans are required to provide annual plan funding notices to all participants and beneficiaries.

129. At all relevant times, Defendant Health System has been the administrator of the Plan.

130. At no time has the Health System furnished Plaintiffs or any member of the Class with a Funding Notice with respect to the Plan pursuant to ERISA § 101(f), 29 U.S.C. § 1021(f).

131. As the Administrator of the Plan, Defendant Health System has violated ERISA § 101(f) by failing to provide each participant and beneficiary of the Plan with the Funding Notice required by ERISA § 101(f), and as such may be required by the Court to pay Plaintiffs and each class member up to $110 per day (as permitted by 29 C.F.R. section 2575.502(c)(3)) for each day that Defendant has failed to provide Plaintiffs and each Class member with the notice required by ERISA § 101(f), 29 U.S.C. § 1021(f).

F. Pension Benefit Statements

132. Under ERISA § 105(a)(1), 29 U.S.C. § 1025(a)(1), administrators of defined benefit plans are required to furnish a pension benefit statement at least once every three years to each participant with a nonforfeitable accrued benefit and who is employed by the employer maintaining the plan at the time the statement is to be furnished. The administrator must also furnish a pension benefit statement to any participant or beneficiary upon request.

133. At all relevant times, Defendant Health System has been the Administrator of the Plan.

134. In every year since at least 2002, the Health System has failed to furnish Plaintiffs or any member of the Class with a Pension Benefit Statement with respect to the Plan pursuant to ERISA § 105(a)(1), 29 U.S.C. § 1025(a)(1).

135. As the Administrator of the Plan, Defendant Health System has violated ERISA § 105(a)(1) and as such the Court may require it to pay Plaintiffs and each Class member up to $110 per day (as permitted by 29 C.F.R. § 2575.502(c)(3)) for each day that

Defendant has failed to provide Plaintiffs and each Class member with the Pension Benefit Statements required by ERISA § 105(a)(1), 29 U.S.C. § 1025(a)(1).

THIRD CLAIM FOR RELIEF

Failure to Provide Minimum Funding Against Defendants Health System, Ministry Services Corporation, and Province (ERISA §§ 302 and 502(a)(3), 29 U.S.C. §§ 1082, 1132(a)(3))

136. Plaintiffs incorporate and re-allege by reference the foregoing paragraphs as if fully set forth herein.

137. ERISA § 302, 29 U.S.C. § 1082, establishes minimum funding standards for defined benefit plans that require employers to make minimum contributions to their plans so that each plan will have assets available to fund plan benefits if the employer maintaining the plan is unable to pay benefits out of its general assets.

138. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), permits a plan participant to bring a suit to obtain appropriate equitable relief to enforce the provisions of Title I of ERISA or to enforce the terms of a plan.

139. As the employer maintaining the Plan, the Health System was responsible for making the contributions that should have been made pursuant to ERISA § 302, 29 U.S.C. § 1082, at a level commensurate with ERISA's requirements.

140. Each year since at least 2002, the Health System has failed to make contributions in satisfaction of the minimum funding standards of ERISA § 302, 29 U.S.C. § 1082.

141. By failing to make the required contributions to the Plan, Defendant Health System has violated ERISA § 302, 29 U.S.C. § 1082 each year since at least 2002.

142. As members of the same controlled group as the Health System, Defendant Ministry Services Corporation and Defendant Province are jointly and severally liable for the failure to meet ERISA's minimum funding standards with respect to the Health System Retirement Plan. 29 U.S.C. § 1082(b)(2).

143. As a result of the failure of Defendants Health System, Ministry Services Corporation and Province to fund the Plan in accordance with ERISA's minimum funding

standards, Plaintiffs and Class Members face a substantial risk of their pensions being lost or severely reduced.

FOURTH CLAIM FOR RELIEF

Failure to Establish the Plan Pursuant to a Written Instrument Under ERISA (ERISA §§ 402, 502(a)(3), 29 U.S.C. §§ 1102, 1132(a)(3))

144. Plaintiffs incorporate and re-allege by reference the foregoing paragraphs as if fully set forth herein.

145. ERISA § 402, 29 U.S.C. § 1102, provides that every plan will be established pursuant to a written instrument which will, among other things, "provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of [Title I of ERISA]."

146. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), permits a plan participant to bring a suit to obtain appropriate equitable relief to enforce the provisions of Title I of ERISA or to enforce the terms of a plan.

147. Although the benefits provided by the Plan were described to the employees and retirees of the Health System (and/or its affiliates and subsidiaries) in various written communications, the Plan has not been established pursuant to a written instrument meeting the requirements of ERISA § 402, 29 U.S.C. § 1102.

148. As Defendant Health System has been responsible for maintaining the Plan and has amendment power over the Plan, Defendant Health System violated § 402 by failing to promulgate written instruments in compliance with ERISA § 402, 29 U.S.C. § 1102 to govern the Plan operations and administration.

FIFTH CLAIM FOR RELIEF

Breach of Fiduciary Duty Against Fiduciary Defendants (ERISA §§ 404, 409, 502(a)(2), 29 U.S.C. §§ 1104, 1109, 1132(a)(2))

149. Plaintiffs incorporate and re-allege by reference the foregoing paragraphs as if fully set forth herein.

150. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), provides that a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

A. for the exclusive purpose of:

i. providing benefits to participants and beneficiaries; and

ii. defraying reasonable expenses of administering the plan; [and]

B. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . .

151. ERISA § 409, 29 U.S.C. § 1109, provides, inter alia, that any person who is a fiduciary with respect to a plan and who breaches any of the responsibilities, obligations, or duties imposed on fiduciaries by ERISA shall be personally liable to make good to the plan any losses to the plan resulting from each such breach and to restore to the plan any profits the fiduciary made through use of the plan's assets. ERISA § 409 further provides that such fiduciaries are subject to such other equitable or remedial relief as a court may deem appropriate.

152. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), permits a plan participant, beneficiary, or fiduciary to bring a suit for relief under ERISA § 409.

153. As fiduciaries with respect to the Plan, Fiduciary Defendants had the duty to comply with and enforce ERISA §§ 101-105, 302, and 402, 29 U.S.C. §§ 1021-1025, 1082, and 1102.

154. Since at least 2002, Fiduciary Defendants have not complied with and enforced any of the provisions of ERISA set forth in paragraph 153 with respect to the Plan.

155. By failing to enforce the provisions of ERISA set forth in paragraph 153, Fiduciary Defendants breached the fiduciary duties that they owed to Plaintiffs and the Class under ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1). These fiduciary breaches include, but are not limited to:

- Failure to act prudently and solely in the interests of Plan participants and beneficiaries by setting a funding policy likely to meet the pension obligations of the Plan;
- Failure to act prudently and solely in the interests of Plan participants and beneficiaries by taking all reasonable and necessary steps to enforce the rights of the Plan to collect adequate contributions from the Participating Employers, including the Health System, and the participating hospitals;
- Failure to take appropriate steps—including, but not limited to appointing an independent fiduciary—to address the conflict of interest that rendered Fiduciary Defendants incapable of fulfilling their fiduciary duties under ERISA;
- Failure to communicate benefit information to Plan participants in the manners specified under ERISA; and
- Failure to ensure compliance with ERISA's basic reporting requirements.

156. The failure of Fiduciary Defendants to create and enforce adequate funding for the Plan has resulted in a loss to the Plan equal to the forgone funding and earnings thereon, and this failure has profited Defendant Health System by providing it the use for its general business purposes of money that it should have paid to the Plan.

SIXTH CLAIM FOR RELIEF

Prohibited Transactions Against Fiduciary Defendants
(ERISA §§ 406, 502(a)(2), (a)(3), 29 U.S.C. §§ 1106, 1132(a)(2), (a)(3))

157. Plaintiffs incorporate and re-allege by reference the foregoing paragraphs as if fully set forth herein.

158. ERISA § 406(a)(1)(B), 29 U.S.C. § 1106(a)(1)(B), prohibits a fiduciary with respect to a plan from directly or indirectly causing a plan to extend credit to a party in interest, as defined in ERISA § 3(14), 29 U.S.C. § 1002(14), if he or she knows or should know that such transaction constitutes an extension of credit to a party in interest.

159. ERISA § 406(b)(2), 29 U.S.C. § 1106(b)(2), prohibits a fiduciary from acting in his individual or in any other capacity in any transaction involving the plan on behalf of a party whose interests are adverse to the plan or the interests of its participants or beneficiaries.

160. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), permits a plan participant to bring a suit for relief under ERISA § 409.

161. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), permits a plan participant to bring suit to obtain appropriate equitable relief to enforce the provisions of Title I of ERISA or to enforce the terms of a plan.

162. For the reasons set forth in paragraph 26, the Health System was at all relevant times a party in interest with respect to the Plan under ERISA § 3(14)(E) and (H), 29 U.S.C. § 1002(14)(E) and (H).

163. By failing to set a prudent funding policy, Fiduciary Defendants extended credit from the Plan to the Health System in violation of ERISA § 406(a)(1)(B), 29 U.S.C. § 1106(a)(1)(B).

164. By failing to enforce the funding obligations created by ERISA and owed to the Plan, Defendants extended credit from the Plan to the Health System in violation of ERISA § 406(a)(1)(B), 29 U.S.C. § 1106(a)(1)(B).

165. By continuing to underfund the Plan, and failing to set a prudent funding policy, Fiduciary Defendants have acted on behalf of the Health System, a party with interests adverse to the Plan in transactions involving the Plan in violation of ERISA § 406(b)(2), 29 U.S.C. § 1106(b)(2).

166. The failure of Defendants to enforce the funding obligations owed to the Plan has resulted in a loss to the Plan equal to the forgone contributions and earnings thereon.

167. The failure of Defendants to enforce the funding obligations owed to the Plan has profited Defendant Health System by providing it the use of money owed to the Plan for its general business purposes.

//

VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that judgment be entered against the Defendants on all claims and requests that the Court award the following relief:

A. Certifying this action as a class action pursuant to Fed. R. Civ. P. 23.

B. Declaring that the Health System Plan is an employee benefit plan within the meaning of ERISA § 3(2), 29 U.S.C. § 1002(2), is a defined benefit pension plan within the meaning of ERISA § 3(35), 29 U.S.C. § 1002(35), and is not a Church Plan within the definition of ERISA § 3(33), 29 U.S.C. § 1002(33),

C. Ordering the Health System to reform the Plan to bring the Plan into compliance with ERISA and to have the Health System Plan comply with ERISA including as follows:

i. Revising Plan documents to reflect that the Plan is a defined benefit plan regulated by ERISA.

ii. Requiring the Health System and members of the Controlled Group to fund the Health System Plan in accordance with ERISA's funding requirements, disclose required information to the Health System Plan participants and beneficiaries, and otherwise comply with all other reporting, vesting, and funding requirements of Parts 1, 2 and 3 of Title I of ERISA, 29 U.S.C. §§ 1021-31, 1051-61, and 1081-85.

iii. Requiring the Health System to comply with ERISA reporting and disclosure requirements, including by filing Form 5500 reports; distributing ERISA-compliant Summary Plan Descriptions, Summary Annual Reports and Participant Benefit Statements; and providing Notice of the Health System Plan funding status and deficiencies.

D. Declaring that the Ministry Services Corporation and the Province are members of the same controlled group as the Health System, and are thus jointly and severally liable for the contributions necessary to provide the plan with the minimum funding required by ERISA.

E. Requiring Fiduciary Defendants to make the Health System Plan whole for all contributions that should have been made pursuant to ERISA funding standards, and for interest and investment income on such contributions, and requiring Defendant Health System to disgorge any profits accumulated as a result of fiduciary breaches.

F. Granting a preliminary and permanent injunction removing the Health System and any other appointed Plan fiduciaries, enjoining all other Defendants and current Plan fiduciaries from serving in any fiduciary capacity with respect to the Health System Retirement Plan, and appointing one or more independent fiduciaries to hold the Health System Plan assets in trust, to manage and administer the Health System Plan and their assets, and to enforce the terms of ERISA.

G. Requiring the Health System to pay a civil money penalty of up to $110 per day to Plaintiffs and each Class member for each day it failed to inform Plaintiffs and each Class member of its failure to fund the Plan in accordance with ERISA's requirements.

H. Requiring the Health System to pay a civil money penalty of up to $110 per day to Plaintiffs and each Class member for each day it failed to provide Plaintiffs and each Class member with a Funding Notice.

I. Requiring the Health System to pay a civil money penalty of up to $110 per day to Plaintiffs and each Class member for each day it failed to provide a benefit statement under ERISA § 105(a)(1)(B), 29 U.S.C. § 1025(a)(1)(B).

J. Ordering declaratory and injunctive relief as necessary and appropriate, including enjoining the Defendants from further violating the duties, responsibilities, and obligations imposed on them by ERISA, with respect to the Health System Plan.

K. Awarding, declaring or otherwise providing Plaintiffs and the Class all relief under ERISA § 502(a), 29 U.S.C. § 1132(a), or any other applicable law, that the Court deems proper and such appropriate equitable relief as the Court may order, including an accounting, surcharge, disgorgement of profits, equitable lien, constructive trust, or other remedy.

L. Awarding to Plaintiffs attorneys' fees and expenses as provided by the common fund doctrine, ERISA § 502(g), 29 U.S.C. § 1132(g) and/or other applicable doctrine.

M. Awarding to Plaintiffs taxable costs pursuant to ERISA § 502(g), 29 U.S.C. § 1132(g), 28 U.S.C. § 1920, and other applicable law.

N. Awarding to the Plan pre-judgment interest on any amounts awarded pursuant to law.

Dated: October 21, 2014

Respectfully Submitted,

LEWIS, FEINBERG, LEE,
RENAKER & JACKSON, P.C.

By: _____
Catha Worthman

Jeffrey Lewis (SBN 66587)
Margaret Hassleman (SBN 228529)
Catha Worthman (SBN 230399)
Jacob Richards (SBN 273476)
LEWIS, FEINBERG, LEE,
RENAKER & JACKSON, P.C.
476 9th Street
Oakland, CA 94612
Telephone: (510) 839-6824
Facsimile: (510) 839-7839
jlewis@lewisfeinberg.com
mhasselman@lewisfeinberg.com
cworthman@lewisfeinberg.com
jrichards@lewisfeinberg.com

R. Joseph Barton (SBN 212340)
THE BARTON FIRM LLP
1633 Connecticut Ave., N.W. Suite 200
Washington, DC 20009
Tel: (202) 734-7046
Email: jbarton@thebartonfirm.com
Counsel for the Plaintiff

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

RACHEL ODEN, on behalf of herself and a class of all others similarly situated, *Plaintiff*, v. RICHARD G. ADCOCK, ERNEST H. AGATSTEIN, B. JOSEPH BADALIAN, JAMES BARBER, TERRY BELMONT, CHRIS CARSON, PETER CHADWICK, TY CONNER, MITCHELL CREEM, ANITA CHOU, JEFFREY FLOCKEN, STEPHEN FORNEY, MICHAEL KATZ, JACK KROUSKUP, CHARLES PATTON, JAMES PIERI, ANDREW PINES, DAVID SACHS, CHRISTOBEL E. SELECKY, and STEVEN C. SHARRER, *Defendants*	Case No.: 2:24-cv-07430-CV-RAO **AMENDED CLASS ACTION COMPLAINT**

I. JURISDICTION AND VENUE

1. Plaintiff brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*. This Court has subject matter jurisdiction over this action pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) because this action arises under the laws of the United States and pursuant to 29 U.S.C. § 1132(e)(1).

2. Venue is proper in this District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because the breaches and violations giving rise to the claims occurred in this District.

II. INTRODUCTION

3. This ERISA action is brought on behalf of a Class of participants in and beneficiaries of the Verity Health System Retirement Plan A and Verity Health System Retirement Plan B, alleging that the members of the Verity Health System Benefits Administration Committee breached their fiduciary duties by failing to take steps to protect Plan participants and improperly operating the Plan and the members of the Board breached their fiduciary duties in failing to properly monitor the members of the Benefits Administration Committee.

4. Plaintiff is the surviving daughter of the late Loraine Oden, a nurse who was employed by the Daughters of Charity Health System and a participant in the Plan. Plaintiff was Loraine Oden's beneficiary under the Plan. When her mother passed away in 2008, Plaintiff became entitled to an annuity under the Plan. But in 2020, the Pension Benefit Guaranty Corporation ("PBGC") informed her that her monthly benefit would be reduced from $830.98 to $540.14 because the Plan was underfunded and underinsured. The Plan was underfunded and underinsured because the Plan had been operated as an improper "church plan" and the Plan's fiduciaries took no action to rectify those breaches.

5. Verity Health System ("Verity" or "Verity Health") was the successor to Daughters of Charity Health System, a group of hospitals in southern California.

Daughters of Charity Health System operated its retirement pension plan as if it was a "church plan." But Daughters of Charity Health System was not a church, it had an insufficient relationship with any church, including the Roman Catholic church, to claim that its Plan was a church plan or that it was exempt from ERISA. Had the Daughters of Charity not improperly claimed church plan status, the Plan would have had to meet the funding requirements of ERISA and the plan sponsor/employer would have been paid premiums to the PBGC.

6. Daughters of Charity became Verity Health System in 2015, after the hospitals were bought by a private equity firm. Once hospitals became the Verity Health Systems, the new, avowedly secular ownership amended the Daughters of Charity pension plan (now the Verity Health System Retirement Plan) to make it subject to ERISA and covered by PBGC insurance. But they took no action against the persons who had improperly operated the Plan as a church plan, left the Plan severely underfunded and had failed to pay PBGC premiums.

7. Verity Health System declared bankruptcy in 2018, and the PBGC assumed responsibility for the now terminated Plan in 2019. Because the Plan had only been covered by PBGC insurance for two full years as of the date Verity Health Systems declared bankruptcy, the PBGC only guaranteed 40% of the pension benefits of Plaintiff and the Class.

8. Had the Benefits Administration Committee taken proper corrective action, including by timely filing suit against the former fiduciaries of the Plan who had improperly operated it as a church plan, and/or the prior employer/plan sponsor to require proper funding, they could have remedied the Plan's underfunding. As a result of the Benefits Administration Committee failure to properly take such corrective action as part of its fiduciary duties, Plaintiff and other members of the Class have been harmed by having their benefits reduced as a result of the Plan's underfunding and lack of payment of insurance premiums to

the PBGC for the amount of time it would have ensured fully-insured benefits by the PBGC after Verity declared bankruptcy.

III. INTRA-DISTRICT ASSIGNMENT

9. Plaintiff resides in the Western Division of the Central District of California.

10. Based on the information available to Plaintiff's counsel, Defendants reside in the following areas: Richard G. Adcock resides in Culver City, California, B. Joseph Badalian resides in the Los Angeles area, Chris Carson resides in Long Beach, California, Peter Chadwick resides in the Washington, D.C. area, Anita Chou resides in Irvine, California, Ty Conner resides in Los Altos, California, Stephen Forney resides in Andover Massachusetts, Michael Katz resides in Redwood City California, David Sachs resides in San Diego California and Steven Sharrer resides in Fishers, Indiana. Based on the information available to Plaintiff's counsel, the Director Defendants reside in the following areas: Ernest H. Agatstein resides in Los Angeles California, James Barber resides in La Canada California, Terry Belmont resides in Corona Del Mar California, Mitchell Creem resides in the Los Angeles area, Jeffrey Flocken resides in Irvine California, Jack Krouskup resides in San Mateo California, Charles Patton resides in Del Mar California, James Pieri resides in the New York City area, Andrew Pines resides in Orinda California, and Christobel E. Selecky resides in Laguna Beach California.

11. The alleged breaches took place in the Western Division of the Central District of California.

IV. PARTIES

Plaintiff

12. Plaintiff Rachel Oden is the daughter of the late Loraine Oden. At the time of her death, Loraine Oden was a former employee at St. Francis Medical Center and a participant in the Daughters of Charity Health System Retirement Plan, later renamed Verity Health System Retirement Plan A (the "Plan," and

together with Verity Health System Retirement Plan B, the "Plans"). Plaintiff Oden is Loraine Oden's beneficiary under the terms of the Plan within the meaning of ERISA § 3(8), 29 U.S.C. § 1002(8), because she was a person designated by Loraine Oden to receive an annuity under the Plan in event of Loraine Oden's death.

Defendants

Benefits Administration Committee Defendants

13. The Benefits Administration Committee Defendants are Richard A. Adcock, B. Joseph Badalian, Chris Carson, Peter Chadwick, Anita Chou, Ty Conner, Stephen Forney, Michael Katz and David Sachs. They are the members of the Benefits Administration Committee of the Plan at some point between December 14, 2015, and October 15, 2019

14. Defendant Richard G. Adcock is, according to his LinkedIn profile and company biography, President and CEO of ImmunityBio. His LinkedIn profile also states he was previously CEO of Verity Health System from January 2018 to September 2020 and COO of Verity Health System from September 2017 to December 2017. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Adcock was a member of the Benefits Administration Committee of the Plan from at least 2017 through at least 2019. As the Benefits Administration Committee was designated as the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Adcock was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Based on his LinkedIn profile, Defendant Adcock works in and/or resides in the Los Angeles area.

15. Defendant B. Joseph Badalian is, according to his LinkedIn profile, a Principal at Exact Leaders and the President and CEO of BintlB Inc and was previously the Corporate Chief Operating Officer of Verity Health System from September 2016 to August 2017. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Badalian was a member of the Benefits Administration Committee of the Plan from at least 2016 through at least 2017. As the Benefits Administration Committee was designated as the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Badalian was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Badalian works and/or resides in Huntington Beach, California.

16. Defendant Chris Carson was, based on her LinkedIn profile, a Vice President Human Resources at St. Vincent Medical Center from June 2007 through March 2017 and from March 2017 through March 2018, she was a Special Advisor in Human Resources at Verity Health System. Based on her LinkedIn profile, Defendant Carson was a member of the Benefits Administration Committee during her employment with St. Vincent Medical Center/Verity Health System. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Carson was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Carson resides in Long Beach, California.

17. Defendant Peter Chadwick is, based on his profile on the BRG website, a managing director at BRG and the CFO of Verity Health System. Based on (a) his execution of the Plan's annual Form 5500 for the Plan Year ending April 30, 2019, in which he signed as Plan Administrator, (b) the fact that the Benefits Administration Committee had been designated as the Plan Administrator of the Plan, and (c) a statement in a declaration by Defendant Chadwick dated December 1, 2020, that as the CFO of Verity Health Systems he had been working with attorneys in Verity Health System's Chapter 11 bankruptcy for "approximately 24 months," Defendant Chadwick was a member of the Benefits Administration Committee at least during 2019. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Chadwick was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) during at least 2019. Defendant Chadwick resides in the Washington, D.C. area.

18. Defendant Anita Chou is, according to her LinkedIn profile, CFO at Dignity Health California and, was CFO of Verity Health System from August 2018 to October 2019, SVP of Hospital Finance at Verity Health System from February 2018 to August 2018 and CFO at St. Vincent Medical Center from March 2016 to May 2018. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Chou was a member of the Benefits Administration Committee of Verity from at least 2018 through at least 2019. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Chou was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29

U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Chou resides in Irvine, California 92620.

19. Defendant Ty Conner is, according to his LinkedIn profile, System Executive Director of Capital Markets and Credit Strategy of City of Hope and was previously Treasurer and Interim Corporate Controller of Verity Health System from October 2016 to November 2020. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Conner was a member of the Benefits Administration Committee of Verity from at least 2017 through at least 2019. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Conner was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Conner resides in Los Alto, California.

20. Defendant Stephen Forney is, based on his LinkedIn profile, SVP and CFO of Covenant Health and was previously CFO of Verity Health System from December 2015 to August 2017. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Forney was a member of the Benefits Administration Committee of Verity from at least 2016 through at least 2017. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Forney was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Forney resides in Andover, Massachusetts.

21. Defendant Michael Katz is, based on his LinkedIn profile, Chief Human Resources Officer of Bay Area Hospital and was previously CHRO, SVP of Verity Health System from May 2016 to July 2017. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Katz was a member of the Benefits Administration Committee of Verity from at least 2016 through at least 2017. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Katz was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Katz resides Redwood City, California.

22. Defendant David Sachs is, according to his company biography, Chief Financial Officer of ImmunityBio. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Sachs was a member of the Board of Directors of Verity from at least 2017 through at least 2018. As the Benefits Administration Committee was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Sachs was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Benefits Administration Committee. Defendant Sachs resides in San Diego, California.

23. Defendant Steven C. Sharrer was the Chief Human Resources Officer for Verity Health System between at least August 21, 2017, and April 23, 2019. Based on filings in the Bankruptcy Court for the Central District of California and on information provided by counsel for Defendants Carson, Chadwick and Sherrer,

Defendant Sharrer was a member of the Benefits Administration Committee during his employment with Verity Health System at least from 2017 to 2019. As the Benefits Administration Committee was designated as the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, the members of the Benefits Administration Committee had discretionary authority or responsibility for the administration of the Plan. As a result, Defendant Sharrer was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while he was a member of the Benefits Administration Committee. Defendant Sharrer resides in Fishers Indiana.

Director Defendants

24. The Director Defendants are Ernest H. Agatstein, James Barber, Terry Belmont, Mitchell Creem, Jeffrey Flocken, Jack Krouskup, S. Christina Maggi, Charles Patton, James Pieri, Andrew Pines, and Christobel E. Selecky. The Director Defendants are persons who were the members of the Board of Directors of Verity Health System at some point between December 14, 2015, and October 15, 2019. Under Section 3.1 of the 2015 Plan Document, the Board of Directors of Verity Health System had the authority to appoint members of the Benefits Administration Committee and to remove directors, with or without cause.

25. Defendant Ernest H. Agatstein is, according to his LinkedIn profile, a urologist in the Los Angeles Metropolitan Area and the Founder of West Coast Urology. Based on Verity Health System of California Inc.'s Form 990s filed with the IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, Defendant Agatstein was a member of the Board of Directors of Verity from December 2015 through at least September 2020. As the Board of Directors had discretionary authority under the Plan, Defendant Agatstein was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Agatstein resides in Los Angeles, California.

26. Defendant James Barber was, based on Verity's Form 990s filed with the IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, a member of the Board of Directors from January 2017 through at least September 2020. As the Board of Directors had authority under the Plan, Defendant Barber was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Barber resides in La Cañada, California.

27. Defendant Terry Belmont, was, based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, a member of the Board of Directors from December 2016 through 2019 and was its Secretary in 2018. As the Board of Directors had discretionary authority under the Plan, Defendant Belmont was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Belmont resides in Corona del Mar, California.

28. Defendant Mitchell Creem is, according to his LinkedIn profile, a Principal at GreenRock, Director at Nutex Health, and President of the Bridgewater Health Group and located in Los Angeles, California. Based on Verity's Form 990s filed with the IRS and his bio on the Nutex Health website, Creem was CEO and CAO of Verity Health from October 2015 to July 2017 and was a member of the Board of Directors of Verity Health from December 2015 through at least July 2016. As the Board of Directors had discretionary authority under the Plan, Defendant Creem was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Creem resides in the Silicon Beach area of Los Angeles, California.

29. Defendant Jeffrey Flocken is currently a member of the Board of Beacon Healthcare System according to the Beacon Healthcare's website. Based on Verity's Form 990s filed with the IRS and information provided by counsel for

Defendants Carson, Chadwick and Sherrer, Flocken was a member of the Board of Directors from December 2015 through at least December 2017. As the Board of Directors had discretionary authority under the Plan, Defendant Flocken was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Flocken resides in Irvine, California.

30. Defendant Jack Krouskup is, according to his LinkedIn profile, the Director of Luther Burbank Savings. Based on Verity's Form 990s filed with the IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, Krouskup was Chairman of the Board of Directors of Verity Health Systems from December 2015 through at least April 2021. As the Board of Directors had discretionary authority under the Plan, Defendant Krouskup was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Krouskup resides in San Mateo, California.

31. Defendant Charles Patton is, according to his LinkedIn profile, a Private Equity Investor and Senior Advisor at CBP in the Los Angeles Metropolitan area. Based on Verity's Form 990s filed with the IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, Patton was a member of the Board of Directors from December 2015 through at least September 2020. As the Board of Directors had discretionary authority under the Plan, Defendant Patton was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Patton resides in Del Mar, California.

32. Defendant James Pieri is, according to his LinkedIn profile, Managing Partner Chief Investment Officer of Assured Healthcare Partners. Based on information provided by counsel for Defendants Carson, Chadwick and Sherrer, Patton, Pieri was a member and Secretary of the Board of Directors from at least

2015 through at least 2017. As the Board of Directors had discretionary authority under the Plan, Defendant Pieri was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Pieri is believed to reside in or near New York, New York.

33. Defendant Andrew Pines is, according to his LinkedIn profile, Chief Financial Officer of HBeat Medical and a board member of Public Health Institute in Orinda, California. Based on Verity's Form 990s filed with the IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, Patton, Pines was a member of the Board of Directors starting December 2016 and was Vice Chairman of the Board from July 1, 2017 through at least April 2021. As the Board of Directors had discretionary authority under the Plan, Defendant Pines was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A) while a member of the Board of Directors. Defendant Pines resides in Orinda, California.

34. Defendant Christobel E. Selecky is, according to her LinkedIn profile, a board member of various health related companies and a "Healthcare Entrepreneur" located in Laguna Beach, California. Based on Verity's Form 990s filed with the IRS IRS and information provided by counsel for Defendants Carson, Chadwick and Sherrer, Patton, Selecky was a member of the Board of Directors from January 2017 through at least September 2020. As the Board of Directors had discretionary authority under the Plan, Defendant Selecky was a fiduciary of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A). Defendant Selecky resides in Laguna Beach, California.

V. CLASS ACTION ALLEGATIONS

35. Plaintiff brings this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of the following Class:

> All participants in the Verity Health System Retirement Plan A and Verity Health System Retirement Plan B and beneficiaries of such

participants whose benefits were reduced by the Pension Benefit Guaranty Corporation because the Plans were underfunded and underinsured.

Excluded from the Class are Defendants and their immediate families, any other individual who served as a fiduciary of the Plan and his or her immediate families, persons who served as officers or directors of the Daughters of Charity Health System or Verity Health System and their immediate families, and legal representatives, successors, and assigns of any such excluded persons.

36. **Impracticality of Joinder**. The members of the Class are so numerous that joinder of all members is impracticable. According to a document entitled "Questions and Answers for Participants in the Verity Health System Plans" provided to Plaintiff by the PBGC, there were approximately 7,000 participants in the Verity Health System Retirement Plan A and 1,000 participants in Verity Health System Retirement Plan B at the time of the termination of the Plans in 2019.

37. **Commonality**. The issues of liability are common to all members of the Class and are capable of common answers as those issues primarily focus on Defendants' acts. The common issues include whether Defendants breached fiduciary duties to participants by failing to bring suit against other fiduciaries of the Plans and the appropriate relief for Defendants' violations of ERISA.

38. **Typicality**. Plaintiff's claims are typical of the claims of other members of the Class because their claims arise from the same event, practice, and course of conduct. Specifically, Plaintiff, on behalf of the Class, alleges Defendants breached their fiduciary duties to plan participants and their beneficiaries by failing to seek relief against former fiduciaries of the Plans on behalf of the Plans and their participants to remedy their underfunding in violation of ERISA.

39. **Adequacy**. Plaintiff will fairly and adequately represent the Class. She has no interests antagonistic to or in conflict with those of the Class,

Defendants' have no unique defenses against her that would interfere with her representation of the Class, and she is represented by counsel with extensive experience litigating ERISA class actions.

40. **Rule 23(b)(1)**. The requirements of Fed. R. Civ. P. 23(b)(1) are satisfied as to the Class because adjudications with respect to individual class members would, as a practical matter, be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests.

41. **Rule 23(b)(2)**. The requirements of Fed. R. Civ. P. 23(b)(2) are satisfied as to the Class because Defendants have acted and/or failed to act on grounds generally applicable to the Class, making declaratory and injunctive appropriate with respect to the Class as a whole. The relief sought in this case primarily consists of declarations that Defendants breached their fiduciary duties and appropriate equitable relief for those breaches. As ERISA is based on trust law, any monetary relief consists of equitable monetary relief that would either flow directly by the declaratory or injunctive relief or flows as a necessary consequence of that relief.

42. **Rule 23(b)(3)**. The requirements of Fed. R. Civ. P. 23(b)(3) are also satisfied. The common questions of law and fact concern whether Defendants breached their fiduciary duties to the Plan. Common questions related to liability will necessarily predominate over any individual questions precisely because Defendants' duties and obligations were uniform to all participants and therefore all members of the Class. And a class action is a superior method to other available methods for the fair and efficient adjudication of this action, including because no other litigation concerning this controversy has been filed by any other members of the Class, because this District is the most desirable location for concentrating this litigation given the presence of the majority of Class members in this district, and because of the proximity of witnesses.

VI. FACTUAL ALLEGATIONS

Loraine Oden's Employment with the Daughters of Charity Health System and Participation in the Plan

43. Loraine Oden was employed by the Daughters of Charity Health System from approximately October 27, 1981 through May 5, 2005. During her entire employment by Daughters of Charity Health System, she worked at St. Francis Medical Center as a registered nurse.

44. Loraine Oden passed away on February 8, 2008.

45. During her employment and until her death in 2008, Loraine Oden was a participant within the meaning of ERISA § 3(7), 29 U.S.C. § 1002(7) in the retirement plan sponsored by the Daughters of Charity Health System and later sponsored by Verity. During the time that the Plan was sponsored by the Daughters of Charity Health System, there was no single document that constituted the written instrument of the Plan within the meaning of ERISA § 402, 29 U.S.C. § 1102. Based on the document provided by the PBGC to Plaintiff, as of 2015, the written instrument of the Plan within the meaning of ERISA § 402, 29 U.S.C. § 1102, was entitled the Verity Health System Retirement Plan (Amended and Restated Effective December 14, 2015) ("the 2015 Plan Document").

46. Based on the 2015 Plan Document, the Plan's standard form of benefit was a monthly payment to participants upon retirement. The monthly benefit amount was calculated using a formula that took into account factors including the participant's earnings prior to retirement and years of service.

47. The Plan provided for the election of one of several alternative forms of pension. Loraine Oden elected a form of pension described by the Plan Document as the "contingent retirement income option." This option provided for a reduced retirement income to the retired participant, but provided a contingent annuitant designated by the retired participant a monthly retirement income from the death of the participant through the death of the annuitant.

48. Plaintiff Rachel Oden, Loraine Oden's daughter, was her beneficiary and designated contingent annuitant under the Plan.

49. Upon Loraine Oden's death, Rachel Oden began to receive a monthly benefit in the amount of $830.98.

Background of the Plan

50. The Daughters of Charity Health System was a California not-for-profit corporation organized under, and governed by, California's Nonprofit Corporation Law, California Corporations Code §§ 5000 *et seq.*

51. Until 1995, the Daughters of Charity Health System member hospitals were part of the Daughters of Charity National Health System, which was established in 1986.

52. In 1995, six hospitals—O'Connor Hospital in San Jose, California, St. Louise Regional Hospital in Gilroy, California, Seton Medical Center in Daly City, California, Seton Coastside in Moss Beach, California, St. Francis Medical Center in Lynwood, California, and St. Vincent Medical Center in Los Angeles, California—spun off from the Daughters of Charity National Health System and merged into Catholic Healthcare West.

53. According to the Verity Health System Retirement Plan's Form 5500 for the Plan Year ending December 31, 2015, the Plan was originally effective May 25, 1995, as a result of the spin-off of assets and liabilities from the Daughters of Charity National Health System Retirement Plan.

54. In 2001 and 2002, the six hospitals withdrew from Catholic Healthcare West and reincorporated as the Daughters of Charity Health System.

55. The Plan was, until December 14, 2015, operated under the name "The Daughters of Charity Health System Retirement Plan."

56. The Plan covered Daughters of Charity Health System employees at member hospitals St. Francis Medical Center and St. Vincent Medical Center, as well as at the Daughters of Charity Health System's central system office.

57. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System described the benefits provided by the Plan to employees in various communications, but never established the Plan pursuant to a written instrument.

58. The Daughters of Charity Health System was responsible for setting the funding requirements of the Plan, as well as setting a funding policy for the Plan. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System failed to set a funding policy that would adequately fund the anticipated obligations of the Plan every year since at least approximately 2010.

59. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System had failed to make contributions to the Plan in satisfaction of the minimum funding requirements of ERISA § 302, 29 U.S.C. § 1082 since at least 2002.

60. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), in 2012, the Daughters of Charity Health System adopted a funding policy that amortized over ten years the unfunded liability as of January 1, 2012, and required the Health System to make payments accordingly. By that point, the Plan was already underfunded by millions of dollars.

61. As of December 31, 2013, the Daughters of Charity National Health System Retirement Plan was underfunded by more than $229 million.

62. By adopting a funding policy that amortized over ten years the significant unfunded liabilities of the plan, the Daughters of Charity Health System made the decision not to address the Plan's severe underfunding in a timely fashion, instead endangering the retirement security of thousands of Plan participants.

63. In setting a funding policy that was so profoundly inadequate, the Daughters of Charity Health System and other fiduciaries of the Plan breached their duties under ERISA § 404(a)(1)(A) and (B), 29 U.S.C. § 1104(a)(1)(A) (B), to administer the plan prudently and in the best interests of Plan participants and beneficiaries.

64. According to the Plan's Form 5500 for the Plan Year ending December 31, 2015, the Daughters of Charity Health System and its Benefits Administration Committee operated the Plan as if it were a "church plan" described in IRS Code section 414(e) and operated the Plan as if it was exempt from Title I and Title IV of ERISA.

65. Yet the Plan was not, in fact, a church plan under ERISA. Under ERISA § 3(33), 29 U.S.C. § 1002(33), only two types of plans may qualify as a church plan. *First*, under ERISA § 3(33)(A), 29 U.S.C. § 1002(33)(A), a plan established and maintained by a church or convention or association of churches, can qualify under certain circumstances and subject to the restrictions of ERISA § 3(33)(B), 29 U.S.C. § 1002(33)(B). *Second*, under ERISA § 3(33)(C)(i), 29 U.S.C. § 1002(33)(C)(i), a plan can qualify if it is maintained by an organization, the principal purpose or function of which is the administration or funding of a plan for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or convention or association of churches, subject to the restrictions of ERISA § 3(33)(B) , 29 U.S.C. § 1002(33)(B).

66. First, this Plan was established by the Daughters of Charity Health System, not by a church or convention or association of churches. Therefore the Plan was not a church plan under ERISA § 3(33)(A), 29 U.S.C. § 1002(33)(A).

67. Second, this Plan was maintained by the Daughters of Charity Health System and by the Benefits Administration Committee that had been delegated

plan administration responsibilities. The principal purpose or function of the Daughters of Charity Health System was operating a system of hospitals, not the administration or funding of a retirement plan. The Benefits Administration Committee also was not associated with a church. Rather, it was associated with the Daughters of Charity Health System, which was not a church, and operated like any other secular, nonprofit, multi-hospital health system.

68. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), by 2014 the Daughters of Charity Health System had more than 7,500 employees.

69. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System specifically did not limit employment to those of the Catholic faith, instead hiring employees without any reference to creed or religion.

70. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the management of the Daughters of Charity Health System was composed primarily of lay people. Its executive officers received compensation in line with executive officers of other hospital systems. At least ten officers or key employees received reportable compensation in excess of half a million dollars in 2013.

71. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System included numerous clinics, physician groups, and individual physician practices throughout California. Many of these practices provided medical services contradicting the teachings of the Roman Catholic Church, including prescribing contraceptives and performing sterilization procedures.

72. Based on the Complaint in *Morris v. Daughters of Charity Health System*, 3:14-cv-04681-VC (N.D. Cal.), the Daughters of Charity Health System

employed chaplains of non-Catholic faiths and offered contact with the minister, priest, rabbi, or spiritual leader of its patients' choosing.

73. Based on Plaintiff's conversations with her late mother, Loraine Oden, there was no requirement for employees or patients of hospitals associated with the Daughters of Charity Health System to attend mass or otherwise participate in Roman Catholic worship services.

74. As a result of the foregoing, the Daughters of Charity Health System thus lacked "common religious bonds and convictions" with the Roman Catholic Church in the sense of ERISA 3(33)(C)(iv).

75. On information and belief, the Benefits Administration Committee had no separate association with the Roman Catholic Church. The Benefits Administration Committee thus lacked "common religious bonds and convictions" with the Roman Catholic Church in the sense of ERISA 3(33)(C)(iv).

76. Therefore, the Plan was not a church plan under ERISA.

Daughters of Charity Health System Becomes Verity Health System

77. Based on filings in the Bankruptcy Court for the Central District of California, in July of 2015, the Daughters of Charity Health System closed a recapitalization transaction with Blue Mountain Capital Management (the "Verity Transaction"). In the Verity Transaction, the Daughters of Charity Health System was renamed Verity Health System.

78. Based on contemporaneous news coverage of the Verity Transaction by Catholic Health World, any relationship between Daughters of Charity Province of the West and the hospital system ended at the time of the transaction. Verity Health System was an avowedly secular nonprofit.

79. Based on the 2015 Plan Document, the Plan was amended and restated at that time so as to make it expressly subject to the requirements of ERISA because it was "no longer intended to be a 'church plan' ... and is therefore subject to, and is intended to comply with, Title I and Title IV of ERISA."

80. Based on the Form 5500 for Verity Health System Retirement Plan B for the period ending December 31, 2016, the Board of Directors of Verity Health Systems converted the Verity Health System Retirement Plan into the Verity Health System Retirement Plan A effective December 31, 2016. At the same time, certain assets of the Plan and certain participants in the Plan were spun off into the Verity Health System Retirement Plan B.

81. On information and belief, the terms of Verity Health System Retirement Plan B were materially similar to the terms of the Plan and the Plan was administered by the same Benefits Administration Committee.

82. According to a declaration dated April 23, 2019, from Carlos De la Parra who was a director of Willis Towers Watson, actuary to Verity Health Systems for Verity Health System Retirement Plan A and Verity Health System Retirement Plan B, the Plans "were significantly underfunded when Verity took them over on December 14, 2015."

Defendants Knew Or Should Have Known of the Existence of Issues With Daughters of Charity's Claimed Church Plan Exemption

83. Not only would all of the Defendant been aware of the significant underfunding of the Plans, but by 2015, there were a number of lawsuits challenging the claimed church plan status of plans like these Plans.

84. By July 26, 2016, the Ninth Circuit had issued a decision in *Rollins v. Dignity Health*, 830 F.3d 900, 905 (9th Cir. 2016), holding that "in order to qualify for the church-plan exemption under [ERISA], a plan must have been established by a church *and* maintained either by a church or by a principal-purpose organization."

85. By June 2017, the Supreme Court had issued a decision in *Advocate Health Care Network v. Stapleton*, 581 U.S. 468, 483 (2017) holding that ERISA provides (1) that a "church plan" means a "plan established and maintained ... by a

church" and (2) that a "plan established and maintained ... by a church" is to "include[ ] a plan maintained by" a principal-purpose organization.

86. These decisions were widely published in a variety of publications designed for employers who sponsor pension plans and those in the healthcare industry including the following:

- *Supreme Court to Consider Health System Church Plan Status*, HealthLeadersMedia (Dec. 12, 2016), https://www.healthleadersmedia.com/finance/supreme-court-consider-health-system-church-plan-status
- *Supreme Court Ruling Did Not Resolve Church plan Challenges* PlanSponsor (June 14, 2017), *https://www.plansponsor.com/supreme-court-ruling-did-not-resolve-church-plan-challenges/;*
- *9th Circuit Agrees Dignity Health Pension Plan is Not A Church Plan*, Plan Advisor (July 29, 2016), *https://www.planadviser.com/9th-circuit-agrees-dignity-health-pension-plan-is-not-a-church-plan/*;

87. By December 2015 and thereafter, persons who were officers and directors of healthcare companies like Verity or fiduciaries of pension plans should have and likely would have been aware of the challenges to the claimed church plan status of plans sponsored by entities like Daughters of Charity. To the extent that persons who were fiduciaries of the Verity Plans did not fully understand the legal ramifications of these decisions, there was sufficient publicly reported information by which a prudent and loyal fiduciary should have obtained a legal advice, particularly given the severe underfunding of the Verity Plans and the lack of or limited amount of PBGC insurance available to participants in the Verity Plans given the previously claimed church plan status.

The Plan is Terminated and Plaintiff's Benefits are Reduced

88. Verity Health System filed for bankruptcy protection on August 31, 2018.

89. Based on a document entitled "Questions and Answers for Participants in the Verity Health System Pension Plans" (the "PBGC Q&A") provided to Plaintiff by the Pension Benefit Guaranty Corporation ("PBGC"), Verity Health System Retirement Plan A and Verity Health System Retirement Plan B were terminated as of April 30, 2019.

90. Based on the PBGC Q&A, the PBGC took responsibility as trustee for the Verity Health System Retirement Plan A and Verity Health System Retirement Plan B as of October 15, 2019.

91. Based on the PBGC Q&A, following its termination the Verity Health System Retirement Plan A covered nearly 7,000 people but was only 52% funded—an underfunding of $306 million. At the time of its termination, the Verity Health System Retirement Plan B covered approximately 1,000 people and was 74% funded—an underfunding of $2.8 million.

92. The PBGC is a federal agency created by ERISA to protect pension benefits in defined benefit plans. If a pension plan is insured by the PBGC and it terminates without sufficient money to pay all benefits, PBGC's insurance program will pay participants the benefit provided by the pension plan up to the limits set by law.

93. As the PBGC explained in an Estimated Benefit Calculation provided to Plaintiff, "church plans are not required to obtain PBGC coverage." The Verity Health System Retirement Plan A obtained PGBC coverage on December 14, 2015, when it was amended and restated to make it expressly subject to the requirements of ERISA, and only began paying PBGC insurance premiums from that point forward.

94. Based on an Estimated Benefit Calculation provided by the PBGC to Plaintiff, because the Verity Health System Retirement Plan A had only been covered by PBGC insurance for two full years as of the date Verity Health Systems

declared bankruptcy, the PBGC only guaranteed 40% of the pension benefits of Plaintiff and the Class.

95. As a result of this reduced guarantee, in an Estimated Benefit Calculation provided by the PBGC to Plaintiff the PBGC calculated that Plaintiff's Plan monthly benefit would be reduced from $830.98 to $540.14 beginning September 1, 2020. Had the Plan been operated as an ERISA-covered plan by August 31, 2013, Plaintiff's monthly benefit would have been $830.14.

96. In a form communication, the PBGC explicitly informed Plaintiff that her benefit was being reduced because the Plan had been underfunded and underinsured. Under a heading reading "**Why is my benefit being reduced**?" the PBGC explained:

> PBGC cannot pay your full benefit *because the Verity pension plans were not covered by PBGC insurance for the time period required by law for a full guarantee*. Under federal law, a pension plan must be insured for five full years for the PBGC guarantee to be fully phased-in. PBGC guarantees 20% of the benefit for each full year the plan was insured before the sponsoring employer files for bankruptcy.
>
> When Verity filed for bankruptcy protection on August 31, 2018, the plan had been covered by PBGC only for two full years. This means PBGC can guarantee 40% of your plan benefit. Some participants will receive more than 40% because the pension plan had enough assets to make up part of the shortfall between the PBGC guarantee and the full benefit.

(emphasis added)

97. In June 2020, Plaintiff requested information from the PBGC including "the Verity Health System Plan documents." The only document produced by the PBGC in response was the written instrument of the Verity Health System Retirement Plan, amended and restated December 14, 2015.

98. In March of 2023, Plaintiff requested from the PBGC all the documents described by ERISA § 104(b), including "(1) the latest updated

summary plan description; (2) any summaries of material modifications to the Plan; (3) the latest full annual report, including a statement of assets and liabilities of the plan and accompanying notes as well as a statement of income and expenses of the Plan, and accompanying notes, (4) any summary annual reports for the Plan, (5) any bargaining agreement, trust agreement, contract, or (6) other instruments under which the plan is established or operated, and any applicable amendments, and (7) my annual benefit statements." PGBC responded by producing only its correspondence to Plaintiff dated July 8, 2020, explaining that her monthly benefit was being reduced.

Select Provisions of the 2015 Plan Document

99. Since 2015, the written instrument of the Plan, within the meaning of ERISA § 402, has been the 2015 Plan Document.

100. Section 2.4 of the 2015 Plan Document defined "Administrator" as "the Plan Sponsor or other person (including a committee) appointed to administer the Plan in accordance with Article 3."

101. Section 3.1 of the 2015 Plan Document provided in relevant part that "The Plan will be administered by the Administrator which shall be the Plan Sponsor or any person, including a committee consisting of at least three individuals, appointed from time to time by the Board of Directors."

102. Section 3.2 of the 2015 Plan Document provided in relevant part that "The Administrator will have full discretionary power and authority to administer the Plan in all of its details, subject, however, to the requirements of ERISA. For this purpose the Administrator's discretionary power and authority will include, but will not be limited to, the following: (a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan; (b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan; (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the

Plan; (d) To compute the amount of benefits which will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid; (e) To authorize the payment of benefits; (f) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and (g) To allocate and delegate its fiduciary responsibilities under the Plan, and to designate other persons to carry out any of its fiduciary responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument and in accordance with section 405 of ERISA."

103. Section 3.5 of the 2015 Plan Document provided that "The Administrator will be a "named fiduciary" for purposes of section 402(a)(1) of ERISA with authority to control and manage the operation and administration of the Plan. The Administrator will be responsible, among other things, for complying with the reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA."

Allegations Regarding ERISA's Statute of Limitations

104. ERISA § 413, 29 U.S.C. § 1113 provides that

> No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
>
> > (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
> >
> > (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
>
> except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

105. The violations alleged in this complaint are in the nature of omissions: the failure of the Plan's fiduciaries following its formal amendment and conversion to an ERISA governed plan on December 14, 2015, to take any action against the prior employer, Daughters of Charity Health System or the Plan fiduciaries who had for years improperly operated the Plan as a church plan, leading to its persistent underfunding and failure to pay PBGC premiums.

106. Defendants could have taken corrective action, including bringing suit to cure these violations until at least October 15, 2019, when the PBGC assumed control of the Plans.

107. To the extent the underlying claims against the Daughters of Charity Health System or the Plan fiduciaries were based in ERISA, the statute of limitations on those claims would not have expired until six years after December 14, 2015, or December 14, 2021. To the extent the underlying claims against the Daughters of Charity fiduciaries were based in state law, California's four year statute of limitations for breaches of fiduciary duty would have applied and expired on December 14, 2019.

108. The statute of limitations under ERISA § 413(1)(B) on the claims brought by Plaintiff does not expire until at least October 15, 2025, six years after October 15, 2019.

109. Plaintiff first learned that her benefits would be reduced due to the underfunding and underinsurance of the Plan by a letter from the PBGC in June 2020. But that letter informed Plaintiff that the "pension plan was a church plan, sponsored by a religious organization." Plaintiff did not learn until at least December 2023 (if not later) that the pension plan had not been sponsored by a church or other religious organization for some years prior to the acquisition by Verity. Only sometime after December 2023 did Plaintiff obtain actual knowledge of the facts that the Plan had been administered by the Benefits Administration Committee, the identities of the some of the members of the Benefits

Administration Committee, and the facts that the both the Daughters of Charity Health System and the Benefits Administration Committee lacked common bonds and conviction with the Roman Catholic Church and that the prior fiduciaries of the Plan had failed to take steps to protect the participants by no earlier than December 2023. The statute of limitations under ERISA § 413(2) would thus run no later than December 2026 and Plaintiff's claims are timely.

110. Additionally, as Plan Administrator of the Plan, the Benefits Administration Committee was responsible for filing the annual report of the Plan (known as the Form 5500) with the United States Department of Labor and the Internal Revenue Service. In the Form 5500s beginning with the 2016 Form 5500 filed on October 2017, the Benefits Administration Committee Defendants made the following false and/or misleading statements that concealed the breaches by the Benefits Administration Committee Defendants and the Director Defendants:

a. The 2015 Form 5500 filed in October 2017 and signed by Michael Katz that when the Plan was established and maintained by the Daughters of Charity, it was "exempt from Title I and Title IV of ERISA." The 2015 Form 5500 also stated that "the plan sponsor is no longer "controlled by or affiliated with the Catholic Church." This was misleading because it implied that the Daughters of Charity Health System was controlled by or was affiliated with Roman Catholic Church or had sufficient connection with the Roman Catholic Church for its Plan to qualify as a church plan when it did not.

b. The 2016 Form 5500 filed in October 2017 and signed by Steve Sharrer represented in Note 1 to the Financial Statements that when the Plan was established and maintained by the Daughters of Charity, it "was qualified as a church plan under Section 3(33) of ERISA." This was false because the Plan did not qualify as a church plan. It was also misleading because it suggested that some authority (e.g. the IRS or DOL) had qualified

it as such. Note 1 to the Financial Statements in the 2016 Form 5500s also stated that "the Plan was not subject to ERISA or to audits." This was also false or misleading because the Plan was in fact subject to ERISA and should have been audited.

c. The 2017 Form 5500 filed in October 2018 and signed by Steve Sharrer represented that when the Plan was established and maintained by the Daughters of Charity, it was "a church plan under Section 3(33) of ERISA." This was false because the Plan did not qualify as a church plan. The 2017 Form 5500 also stated that during that time "the Plan was not subject to ERISA or to audits." This was also false or misleading because the Plan was in fact subject to ERISA and should have been audited. The 2017 Form 5500 also stated that once the Daughters of Charity Health System was restructured to become Verity Health System, it "ceased to be controlled by or affiliated with the Roman Catholic Church." This was misleading because it implied that the Daughters of Charity Health System controlled by or was affiliated with Roman Catholic Church or had sufficient connection with the Roman Catholic Church for its Plan to qualify as a church plan when it did not.

d. The 2018 Form 5500 filed in October 2019 and signed by Steve Sharrer again represented in Note 1 to the Financial Statements that when the Plan was established and maintained by the Daughters of Charity, it was "a church plan under Section 3(33) of ERISA." This was false because the Plan did not qualify as a church plan. Note 1 to the Financial Statements to the 2018 Form 5500 also stated that during that time "the Plan was not subject to ERISA or to audits." This was also false or misleading because the Plan was in fact subject to ERISA and should have been audited. Note 1 to the Financial Statements to the 2018 Form 5500 also stated that once the Daughters of Charity Health System was restructured to become Verity

Health System, it "ceased to be controlled by or affiliated with the Roman Catholic Church." This was misleading because it implied that the Daughters of Charity Health System was controlled by or affiliated with Roman Catholic Church or had sufficient connection with the Roman Catholic Church for its Plan to qualify as a church plan when it did not.

e. The 2019 Form 5500 filed in October 2020 and signed by Peter Chadwick represented in Note 1 to the Financial Statements that when the Plan was established and maintained by the Daughters of Charity, it was "a church plan under Section 3(33) of ERISA." This was false because the Plan did not qualify as a church plan. Note 1 to the Financial Statements in the 2019 Form 5500 also stated that during that time "the Plan was not subject to ERISA or to audits." This was also false or misleading because the Plan was in fact subject to ERISA and should have been audited. Note 1 to the Financial Statements in the 2019 Form 5500 also stated that once the Daughters of Charity Health System was restructured to become Verity Health System, it "ceased to be controlled by or affiliated with the Roman Catholic Church." This was misleading because it implied that the Daughters of Charity Health System was controlled by or affiliated with Roman Catholic Church or had sufficient connection with the Roman Catholic Church for its Plan to qualify as a church plan when it did not.

111. While the Form 5500s were signed by a single member of the Benefits Administration Committee, all member of the Committee at the time that the Form 5500 was filed were responsible as part of their ERISA statutory duties and their fiduciary duties to ensure that the information contained in the Form 5500s were accurate. As such, the false and misleading information contained in the Form 5500s are attributable to all of the members of the Benefits Administration Committee at the time when those Form 5500s were filed.

112. As part of their duties to monitor the members of the Benefits Administration Committee, the Director Defendants had an obligation to ensure that the Benefits Administration Committee members were not providing false or misleading information in the Form 5500s. Upon information and belief the Director Defendants either knew or were reckless in not knowing that the information in the Form 5500s was false or misleading.

113. Finally, each of the Defendants were fiduciaries and as such had an affirmative obligation to disclose information known to them that the participants needed to know about their benefits. Each of the Defendants either knew or were reckless in not knowing that the Daughters of Charity Health System was not controlled by and was not affiliated with Roman Catholic Church or had insufficient connection with the Roman Catholic Church for its Plan to qualify as a church plan. Yet, none of the Defendants disclosed this information to Plaintiff or upon information and belief, to other participants or beneficiaries in the Plan.

COUNT I
Breach of Fiduciary Duty in Violation of ERISA § 404(a)(1)(A) and (B), 29 U.S.C. § 1104(a)(1), Against the Benefits Administration Committee Defendants Pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)

114. Plaintiff incorporates the preceding paragraphs as though set forth herein.

115. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), requires that a plan fiduciary discharge his or her duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and …. (B) with "care, skill, prudence, and diligence."

116. Among the assets of an employee benefit plan under ERISA is a "chose in action"—the right to bring an action to recover a debt, money or a thing—including to institute a lawsuit for a breach of fiduciary duties or other violations including failure to properly fund the plan or pay PBGC premiums. Prior

to December 14, 2015, the Daughters of Charity Health System and prior Plan fiduciaries had improperly operated the Plan as a church plan, had failed to comply with ERISA's pension funding requirements, had failed to pay PBGC premiums and breached their fiduciary duties.

117. Pursuant to Section 3.2 of the 2015 Plan Document, the Plan Administrator had "full discretionary power and authority to administer the Plan in all its details.

118. Pursuant to Section 3.2(f) of the 2015 Plan Document, the Plan Administrator had the power to "appoint such agents, accountants, consultants, and actuaries as may be required to assist in administering the Plan."

119. As a result of the provisions in Section 3.2, the Plan Administrator had the power to bring actions on behalf of the Plan and the authority to institute claims against the Plan's prior fiduciaries and employer/plan sponsor.

120. Section 3.1 of the 2015 Plan Document provides that the Plan was administered by "the Administrator which shall be the Plan Sponsor or any person, including a committee consisting of at least three individuals, appointed from time to time by the Board of Directors…."

121. Based on a declaration executed by Defendant Sharrer in connection with the Verity bankruptcy, the Board of Directors of Verity Health Systems appointed the Benefits Administration Committee to act as or on behalf of the Plan Administrator.

122. Based on the Plan's provision giving the Benefits Administration Committee the power to appoint agents as required to assist in managing the Plan, the Benefits Administration Committee Defendants had the power to engage counsel to institute claims against Daughters of Charity Health System and prior Plan fiduciaries.

123. The Benefits Administration Committee Defendants also had the power to institute claims for prohibited transactions under ERISA against Verity

Health Systems because the failure to set a prudent funding policy constituted an extension of credit by the Plan to Verity Health System in violation of ERISA § 406(a)(1)(B), 29 U.S.C. § 1106(a)(1)(B).

124. Alternatively, the Benefits Administration Committee Defendants, had the power to institute claims for breach of fiduciary duty under California state law against Plan fiduciaries and Daughters of Charity Health System (and its successor, Verity Health System) which had caused the persistent and severe underfunding of the Plan and adopted inadequate measures to remedy its severe underfunding.

125. Had the Benefits Administration Committee Defendants instituted claims in litigation against the pre-Verity fiduciaries or the Daughters of Charity Health System pursuant to either ERISA or California state law, Defendants would have recovered assets for the benefit of the Plan that would have mitigated or eliminated the underfunded status of the Plan or could have required payment of PBGC premiums.

126. Had the Benefits Administration Committee Defendants eliminated the underfunded status of the Plan through such litigation prior to October 15, 2019 or provided the proper premium payments, when the PBGC took responsibility for the Plans, the benefits of Plaintiff and other members of the Class would have been paid in full.

127. Had Defendants mitigated the underfunded status of the Plan through such litigation prior to October 15, 2019, when the PBGC took responsibility for the Plans or required payment of the PBGC premiums, the benefits of Plaintiff and other members of the Class would not have been reduced or would have been reduced by less because of the additional Plan assets available for the PBGC to allocate among participants in the Plans.

128. In failing to manage the choses-in-action of the Plans against the pre-Verity fiduciaries, Defendants thus failed to manage the assets of the Plan with

care, skill, diligence, and prudence in violation of ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B).

129. The defendants in such an action would have included Verity Health Systems (as successor of Daughters of Charity Health Systems) as well as former or current members of the Benefits Administration Committee appointed by the Daughters of Charity Health Systems. On information and belief, Defendants' failure to manage the chose-in-action of the Plans against former fiduciaries were motivated at least in part by unwillingness on the part of members of the Benefits Administration Committee to sue themselves, other executives and employees of Verity Health Systems, or Verity Health Systems. Defendants thus placed the interests of themselves, of other executives and employees of Verity Health Systems, and of Verity Health Systems ahead of the interests of participants in the Plans in violation of ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A).

COUNT II
Breach of Duty to Monitor Pursuant to
ERISA § 404(a)(1)(A) & (B), 29 U.S.C. § 1104(a)(1)(A) & (B)
Against the Director Defendants

130. Plaintiff incorporates the preceding paragraphs as though set forth herein.

131. Pursuant to Section 3.1 of the 2015 Plan Document, the Board of Directors of Verity Health System appointed the Benefits Administration Committee and had the power to remove them. Pursuant to that authority, the Director Defendants had a duty to monitor the Trustees' conduct and to take appropriate action if those fiduciaries were not adequately protecting the interests of the ESOP participants, including removing the Trustees and/or correcting any breaches.

132. The Director Defendants knew, or, if they had properly performed their duty to monitor pursuant to prudent monitoring procedures, would have

known that the Daughters of Charity pension plan had been improperly operated as a church plan prior to the Verity Transaction, and that the Benefits Administration Committee Defendants had taken no action to institute litigation against Daughters of Charity Health System and the former fiduciaries of the Plan who had caused it to be improperly operated as a church plan.

133. The Director Defendants nevertheless took no steps to protect Plan participants or otherwise remedy the violations, including by as necessary removing the members of the Benefits Administration Committee and appointing members who would pursue claims against the Daughters of Charity Health System and/or the former fiduciaries of the Plan.

134. By failing to properly monitor and/or take appropriate action against the Benefits Administration Committee Defendants, the Director Defendants breached their fiduciary duties under ERISA § 404(a)(1)(A) & (B), 29 U.S.C. § 1104(a)(1)(A) & (B).

COUNT III
Co-Fiduciary Liability Pursuant to ERISA § 405, 29 U.S.C. § 1105
Against All Defendants

135. Plaintiff incorporates the preceding paragraphs as though set forth herein.

136. ERISA § 405, 29 U.S.C. § 1105, makes a fiduciary of a Plan liable for another fiduciary of the same plan's breach when (2) "by his failure to comply with section 404(a)(1) in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach;" or (3) "he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach."

137. Each of the Defendants knew or through a proper review would have discovered that the Daughters of Charity Health System and the pre-Verity fiduciaries had purported to operate the Plan as a church plan in violation of

ERISA. Had Defendants properly exercised their fiduciary duties, Defendants would have discovered that operating the Plan as a church plan was improper and the prior fiduciaries had breached their fiduciary duties and the prior fiduciaries and the Daughters of Charity Health System engaged in prohibited transactions in violation of ERISA.

138. Had they properly exercised their fiduciary duties, the Benefits Administration Committee Defendants would have been fully informed as to the persistent and severe underfunded status of the plan, the failure to pay PBGC premiums and the lack of any common religious bonds and convictions between either the Daughters of Charity Health System or the Benefits Administration Committee on the one hand and the Roman Catholic Church on the other hand.

139. Because they were empowered to employ legal and other advisors, the failure of the Benefits Administration Committee Defendants to bring suit against the Daughters of Charity Health System and the pre-Verity fiduciaries breached their duties to comply with ERISA § 404(a)(1) in the administration of their specific responsibilities as fiduciaries including by, if necessary, bringing suit against the pre-Verity Transaction fiduciaries and Daughters of Charity Health System. This failure enabled the pre-Verity Transaction fiduciaries and Daughters of Charity Health System to violate ERISA in holding out the Plan as a church plan, persistently and severely underfunding the plan, causing the Plan to extend credit to the Daughters of Charity Health System, and failing to adopt a funding strategy reasonably calculated to address the Plan's underfunding in a timely fashion and failing to pay PBGC premiums.

140. As members of the Board of Directors of Verity Health System, the Director Defendants would have been fully informed as to the persistent and severe underfunded status of the plan, the failure to pay PBGC premiums and the lack of any common religious bonds and convictions between either Daughters of Charity

Health System or the Benefits Administration Committee on the one hand and the Roman Catholic Church on the other hand.

141. Because they had the power to appoint and remove members of the Benefits Administration Committee, the failure of the Director Defendants to monitor the Benefits Administration Committee and, as necessary, remove its members enabled the Benefits Administration Committee Defendants to violate ERISA by violating their fiduciary duties to bring suit against the former fiduciaries of the Plan.

ENTITLEMENT TO RELIEF

142. By virtue of the violations set forth in the foregoing paragraphs, Plaintiff and the Class are entitled pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), to sue each of the Defendants for any appropriate equitable relief to redress the wrongs described above.

PRAYER FOR RELIEF

Wherefore, Plaintiff prays that judgment be entered against Defendants on each claim and be awarded the following relief:

A. Declare that Defendants have each breached their fiduciary duties under ERISA and violated various statutory provisions of ERISA (or, alternatively, breached their fiduciary duties under California state law);

B. Award the equitable remedy of surcharge against Defendants to make Plaintiff and other members of the Class whole;

C. Require Defendants to pay attorneys' fees and costs pursuant to ERISA § 502(g), 29 U.S.C. § 1132(g);

D. Award pre-judgment interest and post-judgment interest; and

E. Award such other and further relief that the Court determines that Plaintiff is entitled to pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) or pursuant to Rule 54(c) of the Federal Rules of Civil Procedure or that is equitable and just.

Dated: January 31, 2025

Respectfully submitted,



R. Joseph Barton (SBN 212340)
THE BARTON FIRM LLP
1633 Connecticut Ave., N.W.
Suite 200
Washington, DC 20009
Tel: (202) 734-7046
Email: jbarton@thebartonfirm.com

Attorney for Plaintiff

Health Care Portfolio

PREMIUM BILL

Insured: DAUGHTERS OF CHARITY HEALTH SYSTEM Date: 06/23/2014

Producer: AON RISK SERVICES CENTRAL, INC.
10700 RESEARCH DRIVE,450
MILWAUKEE, WI 53226-0000

Company: Federal Insurance Company

THIS BILLING IS TO BE ATTACHED TO AND FORM A PART OF THE POLICY REFERENCED BELOW.

Product: Health Care Portfolio

Policy Number: 8224-0373

Policy Period: July 1, 2014 to July 1, 2015

NOTE: - PLEASE RETURN THIS BILL WITH REMITTANCE AND NOTE HEREON ANY CHANGES. BILL WILL BE RECEIPTED AND RETURNED TO YOU PROMPTLY UPON REQUEST.

PLEASE REMIT TO PRODUCER INDICATED ABOVE.

Product	Effective Date	Premium
FIDUCIARY LIABILITY	07/01/14	$[redacted]
CRIME	07/01/14	$[redacted]

* For Kentucky policies, amount displayed includes tax and collection fees.

TOTAL POLICY PREMIUM	$[redacted]
TOTAL INSTALLMENT PREMIUM DUE	$[redacted]

WHEN REMITTING PLEASE INDICATE POLICY OR CERTIFICATE NUMBER

POLICYHOLDER
DISCLOSURE NOTICE OF
TERRORISM INSURANCE COVERAGE

(for policies with no terrorism exclusion or sublimit)
Insuring Company: Federal Insurance Company

You are hereby notified that, under the Terrorism Risk Insurance Act (the "Act"), effective December 26, 2007, this policy makes available to you insurance for losses arising out of certain acts of terrorism. Terrorism is defined as any act certified by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General of the United States, to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States Mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

You should know that the insurance provided by your policy for losses caused by acts of terrorism is partially reimbursed by the United States under the formula set forth in the Act. Under this formula, the United States pays 85% of covered terrorism losses that exceed the statutorily established deductible to be paid by the insurance company providing the coverage.

However, if aggregate insured losses attributable to terrorist acts certified under the Act exceed $100 billion in a Program Year (January 1 through December 31), the Treasury shall not make any payment for any portion of the amount of such losses that exceeds $100 billion.

If aggregate insured losses attributable to terrorist acts certified under the Act exceed $100 billion in a Program Year (January 1 through December 31) and we have met our insurer deductible under the Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds $100 billion, and in such case insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

The portion of your policy's annual premium that is attributable to insurance for such acts of terrorism is: $ **-0-.**

If you have any questions about this notice, please contact your agent or broker.

IMPORTANT NOTICE TO POLICYHOLDERS

Insuring Company: Federal Insurance Company

All of the members of the Chubb Group of Insurance companies doing business in the United States (hereinafter "Chubb") distribute their products through licensed insurance brokers and agents ("producers"). Detailed information regarding the types of compensation paid by Chubb to producers on US insurance transactions is available under the Producer Compensation link located at the bottom of the page at www.chubb.com, or by calling 1-866-588-9478. Additional information may be available from your producer.

Thank you for choosing Chubb.

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio [SM]
General Terms and Conditions Section

DECLARATIONS

Policy Number: 8224-0373

FEDERAL INSURANCE COMPANY
A stock insurance company, incorporated under the laws
of Indiana, herein called the Company

Capital Center, 251 North Illinois, Suite 1100
Indianapolis, IN 46204-1927

THE EXECUTIVE LIABILITY, ENTITY LIABILITY, AND EMPLOYMENT PRACTICES LIABILITY, FIDUCIARY LIABILITY, AND OUTSIDE DIRECTORSHIP LIABILITY COVERAGE SECTIONS (WHICHEVER ARE PURCHASED) PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", OR ANY EXTENDED REPORTING PERIOD. THE APPLICABLE LIMIT(S) OF LIABILITY TO PAY "LOSS" WILL BE REDUCED, AND MAY BE EXHAUSTED, BY "DEFENSE COSTS" UNLESS OTHERWISE SPECIFIED HEREIN. "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR OTHER "LOSS" IN EXCESS OF THE APPLICABLE LIMIT(S) OF LIABILITY. READ THE ENTIRE POLICY CAREFULLY.

Item 1. **Parent Organization:** DAUGHTERS OF CHARITY HEALTH SYSTEM

Principal Address: 26000 ALTAMONT ROAD
LOS ALTOS HILLS, CA 94022

Item 2. **Policy Period:** From 12:01 A.M. on July 1, 2014
To 12:01 A.M. on July 1, 2015
Local time at the address shown in Item 1.

Item 3. Coverage Summary
Description of Coverage(s) purchased:

Executive Liability and:	
Optional Entity Coverage	
Optional Employment Practices Liability Coverage	
Optional Third Party Liability Coverage	
Outside Directorship Liability Coverage	
Fiduciary Liability Coverage	X
Crime Coverage	X
Kidnap/Ransom and Extortion Coverage	

Item 4. Termination of Prior Bonds or Policies: 8224-0373

In Witness Whereof, the Company issuing this policy has caused this policy to be signed by its Authorized Officers, but it shall not be valid unless also signed by a duly Authorized Representative of the Company.

FEDERAL INSURANCE COMPANY

Maureen A. Brundage
Secretary

Paul J. Krump
President

06/23/2014
Date

Authorized Representative

In consideration of payment of the premium and subject to the Declarations and the limitations, conditions, provisions and other terms of this policy, the Company and the Insureds agree as follows:

Territory

1. Coverage shall extend anywhere in the world.

Terms and Conditions

2. Except for these General Terms and Conditions or unless stated to the contrary in any coverage section of this policy, the terms and conditions of each coverage section shall apply only to that coverage section. If any provision in these General Terms and Conditions is inconsistent or in conflict with the terms and conditions of any coverage section, the terms and conditions of such coverage section shall control for purposes of that coverage section. Any defined term referenced in these General Terms and Conditions but defined in a coverage section shall, for purposes of coverage under that coverage section, have the meaning set forth in that coverage section.

Definitions

3. When used in this policy:

Affiliate means any entity added as an affiliate by specific written endorsement to these General Terms and Conditions.

Claim shall have the meaning set forth in the applicable coverage section.

Financial Impairment means the status of an **Organization** resulting from:

(a) the appointment by any state or federal official, agency or court of any receiver, conservator, liquidator, trustee, rehabilitator or similar official to take control of, supervise, manage, liquidate, or rehabilitate such **Organization**; or

(b) such **Organization** becoming a debtor in possession under the United States bankruptcy law or the equivalent of a debtor in possession under the law of any other country.

Insured shall have the meaning set forth in the applicable coverage section.

Manager means any natural person who was, now is or shall become a manager, member of the Board of Managers or equivalent executive of an **Organization** that is a limited liability company.

Organization shall have the meaning set forth in the applicable coverage section.

Parent Organization means the organization designated in Item 1 of the Declarations of these General Terms and Conditions.

Policy Period means the period of time specified in Item 2 of the Declarations of these General Terms and Conditions, subject to prior termination in accordance with Subsection 11 below. If this period is less than or greater than one year, then the limits of liability specified in the Declarations for each coverage section shall be the Company's maximum limit of liability under such coverage section for the entire period.

Subsidiary means any organization while more than fifty percent (50%) of the outstanding securities or rights representing the present right to vote for election of or to appoint directors or trustees of such organization are owned, directly or indirectly, in any combination, by one or more **Organizations**; provided that **Subsidiary** shall not include any **Affiliate**.

Limits of Liability and Retentions

4. Unless stated to the contrary in any coverage section, the limits of liability and retentions shown for each coverage section are separate limits of liability and separate retentions pertaining to the coverage section for which they are shown. Unless stated to the contrary in any coverage section of this policy, the payment of a retention under one coverage section shall not constitute payment of, and shall not reduce, the applicable retention under any other coverage section.

Notice

5. Any notice to the Company with respect to any coverage section shall designate the coverage section under which notice is being given and shall be treated as notice only under the coverage section(s) so designated.

   Notice to the Company of a **Claim** or loss, or of circumstances which could give rise to a **Claim**, shall be given in writing addressed to:

   Attn: Claims Department
   Chubb Group of Insurance Companies
   82 Hopmeadow Street
   Simsbury, Connecticut 06070-7683

   All other notices to the Company shall be given in writing addressed to:

   Attn: Underwriting
   Chubb Group of Insurance Companies
   82 Hopmeadow Street
   Simsbury, Connecticut 06070-7683

   Any such notice shall be effective on the date of receipt by the Company at such address.

Valuation and Foreign Currency

6. All premiums, limits, retentions, loss and other amounts under this policy are expressed and payable in the currency of the United States of America. Except as otherwise provided in any coverage section, if a judgment is rendered, a settlement is denominated or any element of loss under this policy is stated in a currency other than United States of America dollars, payment under this policy shall be made in United States of America dollars at the rate of exchange published in The Wall Street Journal on the date the judgment becomes final, the amount of the settlement is agreed upon or the element of loss is due, respectively.

Subrogation

7. In the event of any payment under this policy, the Company shall be subrogated to the extent of such payment to all the **Insured's** rights of recovery, and such **Insured** shall execute all papers required and shall do everything necessary to secure and preserve such rights, including the execution of such documents necessary to enable the Company effectively to bring suit or otherwise pursue subrogation rights in the name of the **Insured**.

Action Against the Company

8. No action may be taken against the Company unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this policy. No person or entity shall have any right under this policy to join the Company as a party to any action against any **Insured** to determine such **Insured's** liability nor shall the Company be impleaded by such **Insured** or legal representatives of such **Insured**.

Parent Organization Rights and Obligations

9. By acceptance of this policy, the **Parent Organization** agrees that it shall be considered the sole agent of, and shall act on behalf of, each **Insured** with respect to: the submission of any application; the payment of premiums and the receiving of any return premiums that may become due under this policy; the negotiation, agreement to and acceptance of endorsements; the giving or receiving of any notice provided for in this policy; the adjustment of loss amounts; and the receipt or enforcement of payment of loss (and the **Parent Organization** further agrees that it shall be responsible for application of any such payment as provided in this policy). Each **Insured** agrees that the **Parent Organization** shall act on its behalf with respect to all such matters.

Alteration and Assignment

10. No change in, modification of, or assignment of interest under this policy shall be effective except when made by written endorsement to this policy which is signed by an authorized employee of Chubb & Son, a division of Federal Insurance Company.

Termination of Policy or Coverage Section

11. This policy or any coverage section shall terminate at the earliest of the following times:

    (a) sixty (60) days after receipt by the **Parent Organization** of written notice of termination from the Company for any reason other than non-payment of premium;

    (b) ten (10) days after receipt by the **Parent Organization** of written notice of termination from the Company for non-payment of premium;

    (c) upon receipt by the Company of written notice of termination from the **Parent Organization** stating when thereafter such termination shall be effective; provided that this policy or any coverage section may not be terminated by the **Parent Organization** after the effective date of any acquisition of the **Parent Organization** as described in the Changes in Exposure subsection of the applicable coverage section of this policy;

    (d) upon expiration of the **Policy Period** as set forth in Item 2 of the Declarations of these General Terms and Conditions; or

    (e) at such other time as may be agreed upon by the Company and the **Parent Organization**.

    The Company shall refund the unearned premium computed at customary short rates if this policy or any coverage section is terminated by the **Parent Organization**. Under any other circumstances the refund shall be computed pro rata. Payment or tender of any unearned premium by the Company shall not be a condition precedent to the effectiveness of a notice of termination, but such payment shall be made as soon as practicable thereafter.

Termination of Prior Bonds or Policies

12. Any bonds or policies issued by the Company or its affiliates and specified in Item 4 of the Declarations of these General Terms and Conditions shall terminate, if not already terminated, as of the inception of this policy.

Bankruptcy

13. Bankruptcy or insolvency of any **Insured** shall not relieve the Company of its obligations nor deprive the Company of its rights or defenses under this policy.

Headings

14. The descriptions in the headings and sub-headings of this policy are solely for convenience, and form no part of the terms and conditions of coverage.

Schedule of Forms

To be attached to and form part of Company: Federal Insurance Company
Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

Health Care Portfolio General Terms and Conditions Section (Federal)

14-02-12459 (9/06 ed.)

14-02-13444 (10/07 ed.)

14-02-1350 (1/95 ed.)

14-02-19726 (1/13 ed.)

14-02-9103B (12/04 ed.)

14-02-9981 (8/04 ed.)

Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

14-02-11390 (6/13 ed.)

14-02-11594 (11/05 ed.)

14-02-11681 (6/09 ed.)

14-02-11756 (1/06 ed.)

14-02-12019 (5/06 ed.)

14-02-12199 (2/09 ed.)

14-02-12308 (12/09 ed.)

14-02-12395 (2/09 ed.)

14-02-12777 (1/07 ed.)

14-02-13055 (4/07 ed.)

14-02-13562 (5/08 ed.)

14-02-13563 (5/08 ed.)

14-02-13573 (5/08 ed.)

14-02-13761 (1/08 ed.)

14-02-14454 (8/08 ed.)

14-02-19954 (6/13 ed.)

14-02-8785 (9/03 ed.)

Health Care Portfolio Crime Coverage Section (Federal)

Schedule of Forms

To be attached to and form part of Policy No. 8224-0373

Company: Federal Insurance Company

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

14-02-10894 (5/05 ed.)

14-02-11845 (2/06 ed.)

14-02-12104 (6/06 ed.)

14-02-12559 (11/06 ed.)

14-02-12622 (6/09 ed.)

14-02-13300 (7/07 ed.)

14-02-13660 (3/14 ed.)

14-02-19673 (3/13 ed.)

14-02-7402 (10/02 ed.)

14-02-8530 (6/03 ed.)

14-02-8574 (7/03 ed.)

14-02-8673 (10/07 ed.)

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 1

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTION 11 TERMINATION OF POLICY OR COVERAGE SECTION ENDORSEMENT

In consideration of the premium charged, it is agreed that, notwithstanding any provision to the contrary in this policy or any endorsement thereto, the Company shall only have the right to terminate this policy or any coverage section for non-payment of premium; accordingly, any reference to paragraph (a) of Subsection 11, Termination of Policy or Coverage Section, in this policy or any endorsement thereto, is deleted.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 2

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSIDIARY ENDORSEMENT

In consideration of the premium charged, it is agreed that the term **Subsidiary**, as defined in Section 3 Definitions of the General Terms and Conditions Section, is amended by adding the following to the end thereof:

Subsidiary also means any of the following entities:

O'Connor Hospital Foundation
Robert F. Kennedy Medical Center Foundation
Saint Louis Regional Hospital Foundation
Seton Health Services Foundation
St. Francis Medical Center of Lynwood Foundation
St. Vincent Foundation
.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 3

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

CALIFORNIA PREMIUM ENDORSEMENT

In consideration of the premium charged, it is agreed that:

It is agreed that in compliance with the ruling of the Commissioner of Insurance of the State of California and the opinion of the Attorney-General of that state requiring that the premium for all bonds or policies be endorsed thereon, the basic premium charged for the attached bond/policy for the period

From: July 1, 2014

To: July 1, 2015

Is: Seventy Five Thousand Nine Hundred and Forty Two Dollars ($75,942.00)

CALIFORNIA SURCHARGE N/A

ALL OTHER TERMS AND CONDITIONS REMAINED UNCHANGED.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 4

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

PRO RATA CANCELLATION ENDORSEMENT

In consideration of the premium charged, it is agreed that, notwithstanding anything to the contrary in the policy or any endorsements thereto, in the event that this policy is cancelled, any premium refund due to the insured shall be computed on a pro rata basis. However, the refund may be less than pro rata if the insurer has made a loan to the insured for the purpose of payment of premiums for this policy.

The cancellation will be effective even if a refund has not been made or offered.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 5

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND TERMINATION OF PRIOR BONDS OR POLICIES ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) Subsection 12 Termination of Prior Bonds or Policies of the General Terms and Conditions of this policy is amended to read in its entirety as follows:

12. Any bonds or policies issued by the Company or its affiliates and specified in Item 4 of the Declarations of this policy shall terminate, if not already terminated, as of the inception date of this policy. Such prior bonds or policies shall not cover any loss under the Kidnap/Ransom and Extortion coverage section not discovered and notified to the Company prior to the inception date of this policy. Such prior bonds or policies shall not cover any loss under the Crime coverage section not discovered and notified to the Company prior to the inception date of this policy; provided that this provision shall not apply to:

(a) any loss (i) sustained in its entirety and discovered prior to the inception date of this policy, and (ii) notified to the Company in writing on or after the inception date of this policy, provided such notice is in accordance with any applicable reporting, notice or exclusionary provision of the Crime coverage section of such prior bond or policy; or

(b) any loss (i) sustained in its entirety prior to the inception date of this policy, (ii) and discovered and notified to the Company in writing within sixty days following termination of the Crime coverage section of such prior bond or policy, provided such notice is in accordance with any applicable reporting, notice or exclusionary provision of the Crime coverage section of such prior bond or policy.

(2) The second paragraph of Subsection 24 Liability For Prior Losses of the Crime coverage section is deemed amended to the extent necessary to effectuate the purposes and intent of this endorsement.

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio General Terms and Conditions Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 6

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

CALIFORNIA AMENDATORY ENDORSEMENT
TO THE GENERAL TERMS AND CONDITIONS SECTION

In consideration of the premium charged, it is agreed that:

1. Subsection 11. Termination of Policy or Coverage Section (a) of the General Terms and Conditions Section is amended by adding the following at the end of such paragraph (a):

   "provided that, after any Executive Liability, Entity Liability and Employment Practices Liability Coverage Section, Outside Directorship Liability Coverage Section or Fiduciary Liability Coverage Section issued as part of this policy has been in effect for sixty (60) days or more, or is a renewal, the Company may cancel such coverage section, other than for non-payment of premium, only for one or more of the following reasons:

   (1) A judgment by a court or an administrative tribunal that shows an increase in the risk insured against;
   (2) Discovery of fraud or material misrepresentation, by the **Insured** or his or her representative in obtaining the insurance, or by the **Parent Organization** or its representative in pursuing a claim under this policy;
   (3) Discovery of willful or grossly negligent acts or omissions or of any violations of state laws or regulations establishing safety standards, by the **Parent Organization** or its representative, which materially increase any of the risks insured against;
   (4) Failure by the **Parent Organization** or its representative to implement reasonable loss control requirements which were agreed to by the **Parent Organization** as a condition of policy issuance or which were conditions precedent to the use by the Company of a particular rate or rating plan, if the failure materially increases any of the risks insured against;
   (5) A determination by the insurance commissioner that the loss of, or changes in, the Company's reinsurance covering all or part of the risk would threaten the financial integrity or solvency of the Company. A certification made under penalty of perjury to the commissioner by an officer of the Company of the loss of, or change in, reinsurance and that the loss or change will threaten the financial integrity or solvency of the Company if the cancellation of this policy is not permitted shall constitute such a determination unless disapproved by the commissioner within thirty (30) days of the filing;
   (6) A determination by the commissioner that a continuation of this policy would place the Company in violation of the laws of California or the state of the Company's domicile or that the continuation of coverage would threaten the solvency of the Company; or

(7) A change by the **Parent Organization** or its representative in the activities or property of the commercial or industrial enterprise which results in a material added risk, a materially increased risk or a materially changed risk, unless the added, increased, or changed risk is included in this policy."

2. With respect to each coverage section other than the Crime Coverage Section and the Kidnap/Ransom and Extortion Coverage Section, Subsection 11. Termination of Policy or Coverage Section (d) of the General Terms and Conditions Section is amended by deleting the "or" at the end of such paragraph (d) and adding the following:

:

"provided that, non-renewal by the Company is effective only if the Company mails or delivers notice of non-renewal to the **Parent Organization** and to the agent of record, if any, at the mailing address shown on this policy at least sixty (60) but not more than one hundred twenty (120) days before the expiration of the **Policy Period**; or"

3. With respect to each coverage section other than the Crime Coverage Section and the Kidnap/Ransom and Extortion Coverage Section, Subsection 11. Termination of Policy or Coverage Section of the General Terms and Conditions Section is amended further by adding the following paragraphs at the end of such Subsection:

"No notice of nonrenewal by the Company is required in any of the following situations:

(1) the transfer of, or renewal of, this policy without a change in its terms or conditions or the rate on which the premium is based to another insurer within the Chubb Group of Insurance Companies;
(2) if this policy is extended for 90 days or less, provided that the Company has given notice of nonrenewal before such extension;
(3) if the **Parent Organization** has obtained replacement coverage or has agreed, in writing, within sixty days of the termination of this policy, to obtain such coverage;
(4) if the **Parent Organization** requests a change in the terms or conditions or risks covered by this policy within sixty days before the end of the **Policy Period**;
(5) if this policy is for a period of no more than sixty days and the Company notifies the **Parent Organization** at the time of issuance that it may not be renewed; or
(6) if the Company has made a written offer to the **Parent Organization**, within the required time period for doing so under this policy, to renew this policy under changed terms or conditions or at a changed premium rate.

The Company may condition renewal of this policy upon a reduction in limits, elimination of coverages, increase in deductibles or retentions or increase of more than 25% in the rate upon which the premium is based, by mailing or delivering notice of such renewal change(s) to the **Parent Organization** at the mailing address shown on this policy and to the agent of record, if any, at least sixty (60) but not more than one hundred twenty (120) days before the expiration of the **Policy Period**.

If, in connection with any non-renewal or renewal conditioned upon renewal change(s) as described above, the Company does not mail or deliver notice thereof at least sixty (60) days before the expiration of the **Policy Period**, the coverage afforded under this policy shall continue in force with no change in its terms, conditions and limitations for sixty (60) days after the Company mails or delivers such notice."

4. Nothing in this Amendatory Endorsement amends the provisions of Subsection 11. Termination of Policy or Coverage Section of the General Terms and Conditions Section as such section applies to the Crime Coverage Section or the Kidnap/Ransom and Extortion Coverage Section.

5. References in this Amendatory Endorsement to a particular coverage section of the policy are applicable only to the extent that such coverage section has been issued to the **Parent Organization**.

The coverage sections issued to the **Parent Organization** are those set forth in the applicable Declarations and nothing herein is intended to, nor does it, establish coverage under any coverage section that has not been issued to the **Parent Organization** as part of the policy.

The policy will be deemed to have been amended to the extent necessary to effect the purposes of this Amendatory Endorsement.

The regulatory requirements set forth in this Amendatory Endorsement shall supersede and take precedence over any provisions of the policy or any endorsement to the policy, whenever added, that are inconsistent with or contrary to the provisions of this Amendatory Endorsement, unless such policy or endorsement provisions comply with the applicable insurance laws of the state of California.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

Notice of Loss Control Services

Insuring Company: Federal Insurance Company

As a Chubb policyholder, there is valuable loss prevention information available to you. Chubb designs comprehensive risk management services to accurately fit a client's specific risk needs. Consequently, since the needs of different types of health care organizations vary, our risk management activities are flexible enough to adapt to specific client characteristics. Many of these "value-added" services are available to our clients at no additional fee. Below is a description of these services.

Employment Practices Liability (EPL) Loss Prevention Services

- **Chubb EPL Loss Prevention Web Site**
  For information about the program, as well as a way to access many of our available services, go to http://csi.chubb.com/epllossprevention.

- **ChubbWorks.com**
  ChubbWorks.com is a web-based platform that offers multiple services including overviews of employment laws, sample employment policies and procedures, and on-line training. To gain immediate access to ChubbWorks go to **www.chubbworks.com** and register using your policy number.

- ***Employment Practices Loss Prevention Guidelines* Manual**
  Written by Seyfarth Shaw exclusively for Chubb, these two manuals provide overviews of key employment issues for either private or not-for-profit corporations and offer proactive ideas for avoiding employment lawsuits. To order the *Employment Practices Loss Prevention Guidelines* (geared toward private corporations), simply call **1.866.282.9001,** order 14-01-0061, and provide your mailing address. To order the *Employment Practices Loss Prevention Guidelines for Not-For-Profit Organizations,* simply call **1.866.282.9001,** order 14-01-0107, and provide your mailing address.

- **Loss Prevention Consultant Services**
  Chubb has developed a network of more than 120 law firms, human resources consulting firms, and labor economist/statistical firms that offer specialized services for employment issues. In addition to preferred rates for customers, Chubb will reimburse customers for 50% of the cost of the qualified services, up to 10% of the customer's insurance premium. To access the network of consultants and learn more about the consultant services program, go to Chubb's EPL Loss Prevention Web site at http://csi.chubb.com/epllossprevention.

- **Toll-free Hot Line**
  Have a question on how to handle an employment situation? Simply call **1.888.249.8425** to access the nationally known employment law firm of Jackson Lewis Schnitzler & Krupman. We offer customers an unlimited number of calls to the hot line at no additional charge.

If you have any questions on the EPL Loss Prevention program, simply consult http://csi.chubb.com/epllossprevention or email csi-info@chubb.com.

Directors and Officers (D&O) Liability Loss Prevention Services

- ***Directors and Officers Liability Loss Prevention*** **Manual**
  Written by Dan A. Bailey exclusively for Chubb, *Directors and Officers Liability Loss Prevention* discusses general principles governing D&O liability and potential exposures for directors and officers. To order *Directors and Officers Liability Loss Prevention,* simply call **1.866.282.9001,** order 14-01-0035, and provide your mailing address.

- **Basic Risk Management Series**-- ***Workplace Harassment: Awareness and Prevention***
  Even routine tasks can become overwhelming without a few reminders along the way. These easy-to-use informational brochures provide assistance with everyday topics, such as *Workplace Harassment: Awareness and Prevention*. To order *Workplace Harassment Awareness and Prevention,* simply call **1.866.282.9001,** order 14-01-0617, and provide your mailing address

- **Video Lending Library**
  We encourage client risk managers and their staff to borrow educational videos from our risk management video lending library for use in staff training.

Fiduciary Liability Loss Prevention Services

- ***Fiduciary Liability Loss Prevention*** **Manual**
  Written by Dan A. Bailey exclusively for Chubb, *Fiduciary Liability Loss Prevention* discusses general principles governing D&O liability and potential exposures for directors and officers. To order *Fiduciary Liability Loss Prevention,* simply call **1.866.282.9001,** order 14-01-0039, and provide your mailing address.

Crime Loss Prevention Services

- **Crime Loss Prevention Manual**
  Written by KPMG LLP exclusively for Chubb, the Crime Loss Prevention Manual discusses general principles governing workplace crime exposures. To order the Crime Loss Prevention Manual, simply call **1.866.282.9001,** order 14-01-0044, and provide your mailing address.

Kidnap/Ransom & Extortion Loss Prevention Services

- **Kidnap/Ransom & Extortion Loss Prevention Manuals**
  Chubb offers *Managing Terrorism Risks* and *Managing Travel Risks*, written exclusively for Chubb by the Ackerman Group, Inc., an international security consultant. To order the *Managing Terrorism Risks*, simply call **1.866.282.9001,** order 14-01-0179, and provide your mailing address. To order the *Managing Travel Risks*, simply call **1.866.282.9001,** order 14-01-0178, and provide your mailing address.

The services provided are advisory in nature. While this program is offered as a resource in developing or maintaining a loss prevention program, you should consult competent legal counsel to design and implement your own program. No liability is assumed by reason of the services, access or information provided. All services are subject to change without notice.

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio ***SM***
Fiduciary Liability Coverage Section

DECLARATIONS

Policy Number: 8224-0373

FEDERAL INSURANCE COMPANY
A stock insurance company, incorporated under the laws of Indiana, herein called the Company

THIS COVERAGE SECTION PROVIDES CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", OR ANY EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY "LOSS" WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE COSTS", UNLESS OTHERWISE SPECIFIED HEREIN, AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR OTHER "LOSS" IN EXCESS OF THE APPLICABLE LIMIT(S) OF LIABILITY. READ THE ENTIRE POLICY CAREFULLY.

Item 1. **Parent Organization:** DAUGHTERS OF CHARITY HEALTH SYSTEM
26000 ALTAMONT ROAD
LOS ALTOS HILLS, CA 94022

Item 2. Optional Separate Defense Costs Coverage purchased ☐ Yes ☒ No

Item 3. Limits of Liability:

(A)	Each **Fiduciary Claim**:	$10,000,000.00
(B)	All **Defense Costs** and **Settlement Fees** on account of All **Settlement Program Notices**:	$100,000.00
(C)	Each **Policy Period**:	$10,000,000.00
(D)	Separate Defense Costs Limit:	Not Covered

Note: Unless Optional Separate Defense Costs Coverage is purchased pursuant to Item 2 above, the Limits of Liability will be reduced and may be exhausted by **Defense Costs**.

Item 4. Retention:

(A)	Insuring Clause 1 - Fiduciary Liability Coverage:	$50,000.00
(B)	Insuring Clause 2 - Voluntary Settlement Program Coverage:	$0.00

Item 5. Extended Reporting Period:

(A) Additional Period: 1 year

	(B) Additional Premium:	150% of Annualized Premium for the Expiring **Policy Period**

Item 6. Pending or Prior Date:

(A)	Insuring Clause 1:	January 1, 2002
(B)	Insuring Clause 2:	January 1, 2002

In consideration of payment of the premium and subject to the Declarations, the General Terms and Conditions, and the limitations, conditions, provisions and other terms of this coverage section, the Company and the Insureds agree as follows:

Insuring Clauses

Fiduciary Liability Coverage Insuring Clause 1

1. The Company shall pay, on behalf of the **Insureds**, **Loss** for which the **Insureds** become legally obligated to pay on account of any **Fiduciary Claim** first made against the **Insureds** during the **Policy Period**, or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** committed, attempted, or allegedly committed or attempted before or during the **Policy Period** by such **Insureds**, or by any person for whose **Wrongful Acts** the **Insureds** are legally responsible, but only if such **Fiduciary Claim** is reported to the Company in writing in the manner and within the time provided in Subsection 10 of this coverage section.

Voluntary Settlement Program Coverage Insuring Clause 2

2. The Company shall pay, on behalf of the **Insureds**, **Settlement Fees** and **Defense Costs** on account of any **Settlement Program Notice** first given to the Company by written notice during the **Policy Period**, or, if exercised, during the Extended Reporting Period, provided that such **Settlement Fees** and **Defense Costs** are incurred by the **Insureds** after such **Settlement Program Notice** is first given to the Company by written notice.

Definitions

3. When used in this coverage section:

   Administration means:

   (1) advising, counseling or giving notice to **Employees**, participants or beneficiaries with respect to any **Plan**;

   (2) providing interpretations with respect to any **Plan**; or

   (3) handling of records or effecting enrollment, termination or cancellation of **Employees**, participants or beneficiaries under any **Plan**.

   Application means all signed applications, including attachments and other materials submitted therewith or incorporated therein, submitted by the **Insureds** to the Company for this coverage section or for any coverage section or policy of which this coverage section is a direct or indirect renewal or replacement. **Application** shall also include, for each **Insured**, all documents provided by the **Insureds** to the Company in connection with the underwriting or issuance of this coverage section. All such applications, attachments, materials and other documents are deemed attached to, incorporated into and made a part of this coverage section.

Claim means for the purposes of coverage under:

(1) Insuring Clause 1: any **Fiduciary Claim**; or

(2) Insuring Clause 2: any **Settlement Program Notice**.

Defense Costs means that part of **Loss** consisting of reasonable costs, charges, fees (including but not limited to attorneys' fees and experts' fees) and expenses (other than regular or overtime wages, salaries or fees or benefits of the directors, officers or **Employees** of the **Organization**) incurred in defending any **Claim** and the premium for appeal, attachment or similar bonds.

Domestic Partner means any natural person qualifying as a domestic partner under the provisions of any applicable federal, state or local law or under the provisions of any formal program established by the **Organization**.

Employee means any natural person whose labor or service is engaged by and directed by the **Organization** or any **Plan**, including any part-time and temporary employee or any volunteer. **Employee** shall not include any independent contractor.

ERISA means the Employee Retirement Income Security Act of 1974, the English Pension Scheme Act 1993, the English Pensions Act 1995, all as amended, any similar common or statutory law anywhere in the world, and any rules or regulations promulgated under any such Acts or law.

Executive means any natural person who was, now is or shall become:

(a) a duly elected or appointed director, officer, trustee, **Manager**, duly constituted committee member, or in-house general counsel of any **Plan** or any **Organization** chartered in the United States of America; or

(b) a holder of a position equivalent to any position described in (a) above in an **Organization** that is chartered in any jurisdiction other than the United States of America.

Fiduciary Claim means:

(a) a written demand for monetary damages;

(b) a civil proceeding commenced by the service of a complaint or similar pleading;

(c) a criminal proceeding commenced by a return of an indictment or information;

(d) a formal civil administrative or civil regulatory proceeding commenced by the filing of a notice of charges or similar document or by the entry of a formal investigative order or similar document; or

(e) a written notice of commencement of a fact-finding investigation by the U.S. Department of Labor, the U.S. Pension Benefit Guaranty Corporation, or any similar governmental authority located outside the United States, including but not limited to, the Pensions Ombudsman appointed by the United Kingdom Secretary of State for Social Services, the United Kingdom Occupational Pensions Regulatory Authority,

against any **Insured** for a **Wrongful Act**, including any appeal therefrom.
Except as may otherwise be provided in Subsection 8, Subsection 9(f), or Subsection 10(b) of this coverage section, a **Fiduciary Claim** will be deemed to have first been made when, with respect to any civil or criminal proceeding described in (b) or (c) above, such **Fiduciary Claim** is commenced as set forth in this definition or, in the case of a written demand, written notice, or formal civil administrative or civil regulatory proceeding described in (a), (d), or (e) above, when such demand, notice, or proceeding is first received by an **Insured**.

Insured means the **Organization**, any **Plan** and any **Insured Person**.

Insured Person means:

(a) any past, present or future **Executive** or **Employee**; and

(b) any past, present or future natural person trustee or fiduciary of a multi-employer plan, if such person in such capacity is added as an **Insured Person** by specific written endorsement to this coverage section.

Loss means the amount that any **Insured** becomes legally obligated to pay on account of any covered **Fiduciary Claim**, including but not limited to damages, judgments, settlements, pre-judgment and post-judgment interest, **Defense Costs** and, solely with respect to Insuring Clause 2, **Settlement Fees**.

Loss shall not include:

(a) any amount not indemnified by the **Organization** for which the **Insured** is absolved from payment by reason of any covenant, agreement or court order;

(b) any costs incurred by an **Organization** or **Plan** to comply with any order for injunctive or other non-monetary relief, or to comply with an agreement to provide such relief;

(c) any amount incurred by an **Insured** in the defense or investigation of any action, proceeding, investigation or demand that is not then a **Claim** even if (A) such amount also benefits the defense of a covered **Claim**, or (B) such action, proceeding, investigation or demand subsequently gives rise to a **Claim**;

(d) taxes, fines or penalties, including punitive, exemplary or liquidated damages, or the multiple portion of any multiplied damages award, except:

(i) the five percent (5%) or less, or the twenty percent (20%) or less, civil money penalties imposed upon an **Insured** as a fiduciary under Section 502(i) or (l), respectively, of the Employee Retirement Income Security Act of 1974, as amended;

(ii) any civil money penalties imposed upon an **Insured** by the Pension Ombudsman appointed by the United Kingdom Secretary of State for Social Services or by the United Kingdom Occupational Pensions Regulatory Authority, pursuant to the English Pension Scheme Act 1993, the English Pensions Act 1995, or rules or regulations thereunder; provided any coverage for such civil penalties applies only if the funds or assets of the subject **Plan** are not used to fund, pay or reimburse the premium for this coverage section; or

(iii) solely with respect to Insuring Clause 2, **Settlement Fees**;

(e) any amount allocated to non-covered loss pursuant to Subsection 12 of this coverage section; or

(f) any amount not insurable under the law pursuant to which this coverage section is construed.

Organization means the **Parent Organization** and any **Subsidiary**. **Organization** shall also include any **Affiliate** added as an affiliate by specific written endorsement to the General Terms and Conditions Section of this policy.

Plan means:

(a) any **Sponsored Plan**; and

(b) any government-mandated insurance program for workers' compensation, unemployment, social security or disability benefits for **Employees**.

Pollutants means (a) any substance located anywhere in the world exhibiting any hazardous characteristics as defined by, or identified on a list of hazardous substances issued by, the United States Environmental Protection Agency or any state, county, municipal or local counterpart thereof, including, without limitation, solids, liquids, gaseous or thermal irritants, contaminants or smoke, vapor, soot, fumes, acids, alkalis, chemicals or waste materials, or (b) any other air emission, odor, waste water, oil or oil products, infectious or medical waste, asbestos or asbestos products or any noise.

Related Claims means all **Claims** for **Wrongful Acts** based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events.

Settlement Fees means any fees, fines, penalties or sanctions paid by an **Insured** to a governmental authority pursuant to a **Settlement Program** for the actual or alleged inadvertent non-compliance by a **Plan** with any statute, rule or regulation.

Settlement Fees shall not include: (a) any costs to correct the non-compliance, or any other charges, expenses, taxes or damages; or (b) any fees, fines, penalties or sanctions relating to a **Plan**, which, as of the earlier of the inception of this coverage section or the inception of the first policy in an uninterrupted series of policies issued by the Company of which this coverage section is a direct or indirect renewal or replacement, any **Insured Person** knew to be actually or allegedly non-compliant.

Settlement Program means any voluntary compliance resolution program or similar voluntary settlement program administered by the U.S. Internal Revenue Service or the U.S. Department of Labor, including but not limited to, the Employee Plans Compliance Resolution System, the Audit Closing Agreement Program, the Voluntary Compliance Resolution Program, the Walk-in Closing Agreement Program, the Administrative Policy Regarding Self-Correction, the Tax Sheltered Annuity Voluntary Correction Program, the Delinquent Filer Voluntary Compliance Program, and the Voluntary Fiduciary Correction Program, or any similar program administered by a governmental authority located outside the United States.

Settlement Program Notice means prior written notice to the Company by the **Insured** of the **Insured's** intent to enter into a **Settlement Program**.

Sponsored Plan means:

(a) any Employee Benefit Plan, Pension Benefit Plan or Welfare Benefit Plan, as each are defined in **ERISA**, which is operated solely by the **Organization** or jointly by the **Organization** and a labor organization solely for the benefit of the **Employees** or **Executives** of the **Organization** located anywhere in the world and which existed on or before the inception date set forth in Item 2 of the Declarations of the General Terms and Conditions or which is created or acquired after such inception date; provided (i) any coverage with respect to any such **Plan** created or acquired during the **Policy Period** shall apply only for **Wrongful Acts** committed, attempted, or allegedly committed or attempted after the effective date of such creation or acquisition and shall be subject to Subsection 14 of this coverage section, and (ii) any coverage with respect to an employee stock ownership plan created or acquired during the **Policy Period** shall be further subject to Subsection 18 of this coverage section;

(b) any other employee benefit plan or program not subject to **ERISA** which is sponsored solely by the **Organization** for the benefit of the **Employees** or **Executives**, including any fringe benefit or excess benefit plan;

(c) any other plan or program otherwise described in paragraphs (a) or (b) above while such plan or program is being actively developed, formed or proposed by the **Organization** prior to the formal creation of such plan or program; provided, however, no coverage is afforded under this coverage section for any **Claim** against an **Insured** in a settlor or similar uninsured capacity with respect to any plan or program; and

(d) any other plan, fund, or program specifically included as a **Sponsored Plan** by endorsement to this coverage section.

Sponsored Plan shall not include any employee stock ownership plan created or acquired by the **Organization** during the **Policy Period** (except as otherwise provided in Subsection 18 of this coverage section), or any multi-employer plan created before or during the **Policy Period.**

Wrongful Act means with respect to any **Plan**:

(a) any breach of the responsibilities, obligations or duties imposed by **ERISA** upon fiduciaries of the **Sponsored Plan** committed, attempted, or allegedly committed or attempted by an **Insured** in the **Insured's** capacity as such;

(b) any negligent act, error or omission in the **Administration** of any **Plan** committed, attempted, or allegedly committed or attempted by an **Insured** in the **Insured's** capacity as such; or

(c) any other matter claimed against an **Insured** solely by reason of the **Insured's** service as a fiduciary of any **Sponsored Plan**.

Exclusions

4. The Company shall not be liable for **Loss** on account of any **Claim** against an **Insured**:

   (a) based upon, arising from, or in consequence of any fact, circumstance, situation, transaction, event or **Wrongful Act** that, before the inception date set forth in Item 2 of the Declarations of the General Terms and Conditions, was the subject of any notice given under any policy or coverage section of which this coverage section is a direct or indirect renewal or replacement;

   (b) based upon, arising from, or in consequence of any demand, suit, or other proceeding pending against, or order, decree or judgment entered for or against any **Insured**, on or prior to the applicable Pending or Prior Date set forth in Item 6 of the Declarations for this coverage section, or the same or substantially the same fact, circumstance or situation underlying or alleged therein;

   (c) based upon, arising from, or in consequence of:

      (i) any actual, alleged, or threatened exposure to, or generation, storage, transportation, discharge, emission, release, dispersal, escape, treatment, removal or disposal of any **Pollutants**; or

      (ii) any regulation, order, direction or request to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize any **Pollutants**, or any action taken in contemplation or anticipation of any such regulation, order, direction or request,

      including but not limited to any **Claim** for financial loss to any **Organization** or **Plan** or creditors based upon, arising from, or in consequence of any matter described in clause (i) or clause (ii) of this Exclusion 4(c); provided that this Exclusion 4(c) shall not apply to (A) any **Claim** by or on behalf of a beneficiary of or participant in any **Sponsored Plan** based upon, arising from, or in consequence of the diminution in value of any securities owned by the **Sponsored Plan** in any organization other than the **Organization**, if such diminution in value is allegedly as a result of the matters described above in this Exclusion 4(c), or (B) **Loss** (other than fees and expenses incurred in testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing **Pollutants**) incurred by an **Insured Person** for which the **Organization** is not permitted by common or statutory law to indemnify or for which the **Organization** is not able to indemnify by reason of **Financial Impairment**;

   (d) based upon, arising from, or in consequence of bodily injury, mental anguish, emotional distress, humiliation, sickness, disease or death of any person or damage to or destruction of any tangible property including loss of use thereof whether or not it is damaged or destroyed;

   (e) based upon, arising from, or in consequence of the liability of any **Insured** under any contract or agreement; provided that this Exclusion 4(e) shall not apply to the extent that:

      (i) an **Insured** would have been liable in the absence of such contract or agreement; or

      (ii) such liability was assumed in accordance with or under the agreement or declaration of trust pursuant to which the **Plan** was established;

(f) for the failure of the **Insured** to comply with any workers' compensation, unemployment insurance, social security or disability benefits law or any amendments thereto or any rules or regulations promulgated thereunder, or any similar provisions of any federal, state, or local statutory law or common law anywhere in the world, except (i) the Consolidated Omnibus Budget Reconciliation Act of 1985, (ii) the Health Insurance Portability and Accountability Act of 1996, or (iii) any amendments to or any rules or regulations promulgated under such Acts;

(g) for any actual or alleged violation of the responsibilities, obligations or duties imposed by any federal, state, or local statutory law or common law anywhere in the world (including but not limited to the Fair Labor Standards Act), or amendments to or regulations promulgated under any such law, that governs wage, hour and payroll policies and practices ("Wage and Hour Laws"), including but not limited to:

(i) the calculation, timing or manner of payment of minimum wages, prevailing wage rates, overtime pay or other compensation alleged to be due and owing;

(ii) the classification of any organization or person for wage and hour purposes;

(iii) garnishments, withholdings or other deductions from wages;

(iv) child labor;

(v) pay equity or comparable worth; or

(vi) any similar policies or practices;

(h) based upon, arising from, or in consequence of any **Wrongful Act** committed, attempted, or allegedly committed or attempted by a **Subsidiary** or an **Insured Person** of such **Subsidiary** during any time when such entity was not a **Subsidiary**;

(i) based upon, arising from, or in consequence of any actual or alleged employment-related or work-related act, error, omission, misstatement, misleading statement, negligence, policy, practice, or breach of any responsibility, obligation or duty by, on behalf of, or with the consent of any **Insured**;

(j) for any actual or alleged act, error, omission, misstatement, misleading statement, negligence, policy, practice, or breach of any responsibility, obligation or duty by, on behalf of, or with the consent of any **Insured Person** in his or her capacity as a director, officer, manager, trustee, fiduciary, regent, governor, employee, member of staff or faculty, administrator, general counsel, or member of a duly constituted committee of any entity other than an **Organization**;

(k) based upon, arising from, or in consequence of any actual or alleged violation of any federal, state, or local securities law anywhere in the world (including but not limited to the Securities Act of 1933, the Securities Exchange Act of 1934 and the Investment Act of 1940) or amendments to or regulations promulgated under any such laws;

(l) for an accounting of profits made from the purchase or sale by such **Insured Person** of securities of the **Organization** within the meaning of Section 16(b) of the Securities Exchange Act of 1934, any amendments thereto, or any similar provision of any federal, state, or local statutory law or common law anywhere in the world;

(m) based upon, arising from, or in consequence of:

(i) the committing in fact of any dishonest or fraudulent act or omission or any willful violation of any statute or regulation by such **Insured**, as evidenced by (A) any written statement or written document by any **Insured**, (B) any plea of guilty, nolo contendere or no contest, or (C) any judgment or ruling in any judicial, administrative or alternative dispute resolution proceeding; or

(ii) such **Insured** having gained in fact any profit, remuneration or advantage to which such **Insured** was not legally entitled;

(n) for any actual or alleged violation of the responsibilities, obligations or duties imposed by:

(i) the Federal False Claims Act, the Social Security Act, any similar federal, state, or local statutory law or common law anywhere in the world or amendments to or regulations promulgated under any such law; or

(ii) any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world or amendments to or regulations promulgated under any such law,

brought by or on behalf of any federal, state, or local governmental, regulatory or administrative agency or entity, whether such **Claim** is brought in the name of such agency or entity or in the name of any other individual or entity; provided that this Exclusion 4(n) shall not apply to any **Claim** for any actual or alleged violation of Title II of the Health Insurance Portability and Accountability Act of 1996; or

(o) based upon, arising from, or in consequence of any actual or alleged retaliatory treatment against an employee of an **Organization** on account of such individual:

(i) disclosing or threatening to disclose to any person, agency or entity alleged violations of;

(ii) having assisted or testified in or cooperated with a proceeding or investigation regarding alleged violations of; or

(iii) filing any **Claim** against an **Insured** under,

the Federal False Claims Act or the Social Security Act, any similar federal, state, or local statutory law or common law anywhere in the world, any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world, or amendments to or regulations promulgated under any such law.

5. The Company shall not be liable for **Loss**, other than **Defense Costs**:

(a) which constitutes the return or reversion to an employer of any contribution or asset of a **Plan**;

(b) which constitutes:

(i) benefits due or to become due under any **Plan**; or

(ii) benefits which would be due under any **Plan** if such **Plan** complied with all applicable law, including but not limited to **Loss** resulting from the payment of

plaintiff attorneys' fees based upon a percentage of such benefits or payable from a common fund established to pay such benefits,

except to the extent that:

(A) an **Insured** is a natural person and the benefits are payable by such **Insured** as a personal obligation; and

(B) recovery for the benefits is based upon a covered **Wrongful Act**; or

(c) which is based upon, arising from, or in consequence of the failure to collect an employer's contributions owed to a **Plan** unless the failure is because of the negligence of any **Insured**.

Severability of Exclusions

6. (a) No fact pertaining to or knowledge possessed by any **Insured Person** shall be imputed to any other **Insured Person** for the purpose of applying the exclusion set forth in Subsection 4(m) of this coverage section.

(b) Only facts pertaining to and knowledge possessed by any **Executive** of an **Organization** or **Plan** shall be imputed to such **Organization** or **Plan** for the purpose of applying the exclusion set forth in Subsection 4(m) of this coverage section.

Spouses, Estates and Legal Representatives

7. Subject otherwise to the General Terms and Conditions and the limitations, conditions, provisions and other terms of this coverage section, coverage shall extend to **Claims** for the **Wrongful Acts** of an **Insured Person** made against:

(a) the estate, heirs, legal representatives or assigns of such **Insured Person** if such **Insured Person** is deceased or the legal representatives or assigns of such **Insured Person** if such **Insured Person** is incompetent, insolvent or bankrupt; or

(b) the lawful spouse or **Domestic Partner** of such **Insured Person** solely by reason of such spouse or **Domestic Partner's** status as a spouse or **Domestic Partner**, or such spouse or **Domestic Partner's** ownership interest in property which the claimant seeks as recovery for an alleged **Wrongful Act** of such **Insured Person**.

All terms and conditions of this coverage section, including without limitation the Retention, applicable to **Loss** incurred by the **Insured Persons**, shall also apply to loss incurred by the estates, heirs, legal representatives, assigns, spouses and **Domestic Partners** of such **Insured Persons**. The coverage provided by this Subsection 7 shall not apply with respect to any loss arising from an act or omission by an **Insured Person's** estate, heirs, legal representatives, assigns, spouse or **Domestic Partner**.

Extended Reporting Period

8. If the Company or the **Parent Organization** terminates or does not renew this coverage section, other than termination by the Company for nonpayment of premium, the **Parent Organization**, on behalf of all **Insureds**, shall have the sole right, upon payment of the additional premium set forth in Item 5(B) of the Declarations for this coverage section, to an extension of the coverage granted by this coverage section for **Claims** that are (i) first made during the period set forth in Item 5(A) of the Declarations for this coverage section (the "Extended Reporting Period") following the effective date of termination or nonrenewal, and (ii) reported to the Company in writing within the time provided in Subsection 10(a) of this coverage section, but only to the extent such **Claims** are for **Wrongful Acts** committed, attempted, or allegedly committed or attempted before the earlier of the effective date of termination or nonrenewal or the date of the first merger, consolidation, acquisition or **Financial Impairment** event described in Subsection 15 of this coverage section. The offer of renewal terms and conditions or premiums different from those in effect prior to renewal shall not constitute refusal to renew. The right to purchase an extension of coverage as described in this Subsection 8 shall lapse unless written notice of election to purchase the extension, together with payment of the additional premium due, is received by the Company within thirty (30) days after the effective date of termination or nonrenewal. Any **Claim** made during the Extended Reporting Period shall be deemed to have been made during the immediately preceding **Policy Period**. The entire additional premium for the Extended Reporting Period shall be deemed fully earned at the inception of such Extended Reporting Period.

Limit of Liability and Retention

9. (a) The Company's maximum liability for all **Loss** on account of each **Fiduciary Claim** first made during the **Policy Period** and covered under Insuring Clause 1 shall be the Limit of Liability set forth in Item 3(A) of the Declarations for this coverage section. The Company's maximum aggregate liability for all **Loss** on account of all **Claims** first made during the **Policy Period**, whether covered under one or both Insuring Clauses, shall be the Limit of Liability set forth in Item 3(C) of the Declarations for this coverage section.

(b) The Company's maximum aggregate liability for all **Defense Costs** and **Settlement Fees** on account of all **Settlement Program Notices** first given to the Company during the **Policy Period** and covered under Insuring Clause 2 shall be the Limit of Liability set forth in Item 3(B) of the Declarations for this coverage section, which amount shall be part of, and not in addition to, the Limit of Liability for each **Policy Period** set forth in Item 3(C) of the Declarations for this coverage section.

(c) Solely in the event that the Optional Separate Defense Costs Coverage is purchased, as set forth in Item 2 of the Declarations for this coverage section, a separate, additional limit of liability shall be available for **Defense Costs** incurred in connection with **Fiduciary Claims** covered under Insuring Clause 1 ("Separate Defense Costs Limit"). The Company's maximum aggregate liability under the Separate Defense Costs Limit for all **Defense Costs** on account of all **Fiduciary Claims** first made during the **Policy Period** and covered under Insuring Clause 1 shall be the Limit of Liability set forth in Item 3(D) of the Declarations for this coverage section; provided that if such Limit of Liability is exhausted, any additional **Defense Costs** shall reduce and may exhaust the applicable Limits of Liability set forth in Items 3(A) and 3(C) of the Declarations for this coverage section. If the Optional Separate Defense Costs Coverage is not purchased, **Defense Costs** shall

be part of, and not in addition to, the Limits of Liability set forth in Items 3(A) and 3(C) of the Declarations for this coverage section, and the payment by the Company of **Defense Costs** shall reduce and may exhaust such applicable Limits of Liability.

(d) No Retention shall apply to any **Loss** under this coverage section incurred by an **Insured Person** if such **Loss** can not be indemnified by an **Organization** or **Plan** because such **Organization** or **Plan** is either not legally permitted or required to indemnify, or is unable to indemnify, such **Insured Person** by reason of **Financial Impairment**. The Company's liability for all other covered **Loss** (as determined by Subsection 12 of this coverage section) shall apply only to that part of **Loss** on account of each **Claim** which is excess of the applicable Retention set forth in Item 4 of the Declarations for this coverage section. Such Retention shall be reduced only by **Loss** otherwise covered under this coverage section and shall be borne by the **Insureds** uninsured and at their own risk.

(e) If different parts of a single **Claim** are subject to different Retentions, the applicable Retentions will be applied separately to each part of such **Claim**, but the sum of such Retentions shall not exceed the largest applicable Retention.

(f) All **Related Claims** shall be treated as a single **Claim** first made on the date the earliest of such **Related Claims** was first made, or on the date the earliest of such **Related Claims** is treated as having been made in accordance with Subsection 10(b) of this coverage section, regardless of whether such date is before or during the **Policy Period**.

(g) The limit of liability available during the Extended Reporting Period (if exercised) shall be part of, and not in addition to, the Company's maximum aggregate limit of liability for all **Loss** on account of all **Claims** first made during the immediately preceding **Policy Period**.

Reporting and Notice

10. (a) The **Insureds** shall, as a condition precedent to exercising any right to coverage under this coverage section, give to the Company written notice of any **Fiduciary Claim** as soon as practicable, but in no event later than the earliest of the following dates:

(i) if this coverage section expires (or is otherwise terminated) and if no Extended Reporting Period is purchased, sixty (60) days after the effective date of such expiration or termination; or

(ii) the expiration date of the Extended Reporting Period, if purchased;

provided that if the Company sends written notice to the **Parent Organization**, at any time before the date set forth in (i) above with respect to any **Fiduciary Claim**, stating that this coverage section is being terminated for non-payment of premium, the **Insureds** shall give to the Company written notice of such **Fiduciary Claim** prior to the effective date of such termination.

(b) If during the **Policy Period** an **Insured**:

(i) becomes aware of circumstances which could give rise to a **Fiduciary Claim** and gives written notice of such circumstances to the Company as soon as

practicable thereafter but before the expiration or termination of this coverage section; or

(ii) gives written notice to the Company of a **Settlement Program Notice**,

then any **Claim** subsequently arising from such circumstances referred to in (i) above or from the **Settlement Program Notice** referred to in (ii) above, shall be deemed to have been first made during the **Policy Period** in which such written notice described in (i) or (ii) above was first given by an **Insured** to the Company, provided any such subsequent **Claim** is reported to the Company as set forth in Subsection 10(a) above. With respect to any such subsequent **Claim**, no coverage under this coverage section shall apply to loss incurred prior to the date such subsequent **Claim** is actually made.

(c) The **Insureds** shall, as a condition precedent to exercising any right to coverage under this coverage section, give to the Company every demand notice, summons, complaint, or other process received by an **Insured** or **Insured** representative and such information and cooperation as the Company may reasonably require, and shall include in any notice under Subsection 10(a) or (b) a description of the **Claim** or circumstances, the nature of any alleged **Wrongful Acts**, the nature of the alleged or potential damage, the names of all actual or potential claimants, the names of all actual or potential defendants, and the manner in which such **Insured** first became aware of the **Claim** or circumstances.

Defense and Settlement

11. (a) The Company shall have the right and duty to defend any **Claim** covered by this coverage section, even if any of the allegations in such **Claim** are groundless, false or fraudulent. The Company's duty to defend any **Claim** shall cease upon exhaustion of the applicable Limit of Liability.

(b) The Company may make any investigation it deems necessary and may, with the consent of the **Insured**, make any settlement of any **Claim** it deems expedient. If any **Insured** withholds consent to any settlement acceptable to the claimant and the Company (a "Proposed Settlement"), the Company's liability for all **Loss**, including **Defense Costs**, from such **Claim** shall not exceed:

(i) the amount of the Proposed Settlement plus **Defense Costs** incurred up to the date of the **Insured's** refusal to consent to the Proposed Settlement of such **Claim**; plus

(ii) seventy percent (70%) of any **Loss**, including **Defense Costs**, in excess of the amount referenced in paragraph (i) above, incurred in connection with such **Claim**; subject in all events to the applicable Retention and the available Limit of Liability for such **Claim**. The remaining thirty percent (30%) of any **Loss**, including **Defense Costs**, in excess of the amount referenced in paragraph (i) above shall be borne by the **Insured** uninsured and at its own risk, notwithstanding anything to the contrary contained in Subsection 12(a) of this coverage section.

(c) The **Insureds** agree not to settle or offer to settle any **Claim**, incur any **Defense Costs** or otherwise assume any contractual obligation or admit any liability with respect to any **Claim** without the Company's prior written consent. The Company shall not be liable for any settlement made, for any other element of **Loss** incurred,

for any obligation assumed, or for any admission made by any **Insured** without the Company's prior written consent. Provided that the **Insureds** comply with Subsection 11(d) below, the Company shall not unreasonably withhold any such consent.

(d) The **Insureds** agree to provide the Company with all information, assistance and cooperation which the Company may reasonably require and agree that in the event of a **Claim** the **Insureds** will do nothing that could prejudice the Company's position or its potential or actual rights of recovery.

Allocation

12. (a) If in any **Claim** the **Insureds** incur both **Loss** that is covered under this coverage section and loss that is not covered under this coverage section, either because such **Claim** includes both covered and non-covered matters or because such **Claim** is made against both **Insureds** and others, the **Insureds** and the Company shall allocate such amount between covered **Loss** and non-covered loss based on the relative legal and financial exposures of the parties to covered and non-covered matters and, in the event of a settlement in such **Claim**, based also on the relative benefits to the parties from such settlement. The Company shall not be liable under this coverage section for the portion of such amount allocated to non-covered loss.

(b) If the **Insureds** and the Company cannot agree on an allocation of **Loss**:

(i) no presumption as to allocation shall exist in any arbitration, suit or other proceeding; and

(ii) the Company, if requested by the **Insureds**, shall submit the dispute to binding arbitration. The rules of the American Arbitration Association shall apply except with respect to the selection of the arbitration panel, which shall consist of one arbitrator selected by the **Insureds**, one arbitrator selected by the Company, and a third independent arbitrator selected by the first two arbitrators.

Other Insurance

13. If any **Loss** under this coverage section is insured under any other valid insurance policy(ies), then this coverage section shall cover such **Loss**, subject to its limitations, conditions, provisions and other terms, only to the extent that the amount of such **Loss** is in excess of the applicable retention or deductible and limit of liability under such other insurance, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise, unless such other insurance is written only as specific excess insurance over the Limits of Liability provided in this coverage section. Any payment by **Insureds** of a retention or deductible under such other insurance shall not reduce, by the amount of such payment which would otherwise have been covered under this coverage section, the applicable Retention under this coverage section.

Changes in Exposure

Acquisition/Creation of Another Organization

14. If before or during the **Policy Period** any **Organization**:

    (a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or

    (b) acquires another organization by merger into or consolidation with an **Organization**, such that the **Organization** is the surviving entity,

    such other organization and its **Insured Persons** and **Plans** shall be **Insureds** under this coverage section, but only with respect to **Wrongful Acts** committed, attempted, or allegedly committed or attempted by such **Insureds** after such acquisition or creation unless the Company agrees, after presentation of a complete application and all other appropriate information, to provide coverage by endorsement for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by such **Insureds** before such acquisition or creation.

    If, at the time of any such acquisition or creation described above, the total assets of any such acquired organization or new **Subsidiary** exceed fifteen percent (15%) of the total assets of the **Parent Organization** (as reflected in the most recent audited consolidated financial statements of such organization and the **Parent Organization**, respectively, as of the date of such acquisition or creation), then the **Parent Organization** shall give written notice of such acquisition or creation to the Company as soon as practicable, but in no event later than sixty (60) days after the date of such acquisition or creation, together with such other information as the Company may require and shall pay any reasonable additional premium required by the Company. If the **Parent Organization** fails to give such notice within the time specified in the preceding sentence, or fails to pay the additional premium required by the Company, coverage for such acquired or created organization and its **Insureds** shall terminate with respect to **Claims** first made more than sixty (60) days after such acquisition or creation. Coverage for any acquired or created organization described in this paragraph, and for the **Insureds** of such organization, shall be subject to such additional or different terms, conditions and limitations of coverage as the Company in its sole discretion may require.

Acquisition by Another Organization/Financial Impairment

15. If:

    (a) the **Parent Organization** merges into or consolidates with another organization and the **Parent Organization** is not the surviving entity;

    (b) another organization or person or group of organizations and/or persons acting in concert acquires securities or voting rights which result in ownership or voting control by the other organization(s) or person(s) of more than fifty percent (50%) of the outstanding securities or voting rights representing the present right to vote for the election of or to appoint directors, trustees or **Managers** of the **Parent Organization**, or acquires the right to control or direct the managerial decisions of the **Parent Organization**; or

(c) **Financial Impairment** of the **Parent Organization** occurs,

then coverage under this coverage section shall continue until termination of this coverage section, but only with respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by **Insureds** before such merger, consolidation, acquisition or **Financial Impairment**. Upon the occurrence of any event described in (a), (b) or (c) of this Subsection 15, the entire premium for this coverage section shall be deemed fully earned.

The **Parent Organization** shall give written notice of such merger, consolidation, acquisition or **Financial Impairment** to the Company as soon as practicable, but in no event later than sixty (60) days after the date of such merger, consolidation, acquisition or **Financial Impairment**, together with such other information as the Company may require. Upon receipt of such notice and information and at the request of the **Parent Organization**, the Company may provide to the **Parent Organization** a quotation for an extension of coverage (for such period as may be negotiated between the Company and the **Parent Organization**) with respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by **Insureds** before such merger, consolidation, acquisition or **Financial Impairment**. Any coverage extension pursuant to such quotation shall be subject to such additional or different terms, conditions and limitations of coverage and payment of such additional premium, as the Company in its sole discretion may require. If the Company in its sole discretion agrees to provide coverage for such **Claims**, the additional premium specified by the Company must be paid to the Company in full before such coverage becomes effective.

Cessation of Subsidiary

16. In the event an organization ceases to be a **Subsidiary** before or during the **Policy Period**, coverage with respect to such **Subsidiary** and its **Insureds** shall continue until termination of this coverage section, but only with respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly committed or attempted while such organization was a **Subsidiary**.

Termination of Plan

17. If an **Organization** terminates a **Plan** before or after the inception date set forth in Item 2 of the Declarations of the General Terms and Conditions, coverage under this coverage section with respect to such terminated **Plan** and its **Insureds** shall continue until termination of this coverage section for those who were **Insureds** prior to or at the time of such **Plan** termination or who would have been **Insureds** at the time of such termination if this coverage section had then been in effect. Such continuation of coverage shall apply with respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly committed or attempted prior to or after the date the **Plan** was terminated.

Creation or Acquisition of an ESOP

18. Notwithstanding anything in this coverage section to the contrary, if during the **Policy Period** the **Organization** creates or directly or indirectly acquires an employee stock ownership plan ("ESOP"), the **Organization** shall promptly give to the Company written notice thereof together with such other information requested by the Company. The Company shall, at the request of the **Organization**, provide to the **Organization** a quotation for coverage for **Claims** based upon, arising from, or in consequence of such

ESOP, subject to such terms, conditions, limitations of coverage and such additional premium as the Company in its sole discretion may require. Unless the **Insureds** accept such quotation and pay such additional premium within thirty (30) days after receipt of the quotation, no coverage will be available under this coverage section for **Claims** based upon, arising from, or in consequence of such ESOP.

Representations and Severability

19. In issuing this coverage section the Company has relied upon the statements, representations and information in the **Application**. All of the **Insureds** acknowledge and agree that all such statements, representations and information (i) are true and accurate, (ii) were made or provided in order to induce the Company to issue this coverage section, and (iii) are material to the Company's acceptance of the risk to which this coverage section applies.

    In the event that any of the statements, representations or information in the **Application** are not true and accurate, this coverage section shall be void with respect to (i) any **Insured** who knew the facts in the **Application** that were not truthfully and accurately disclosed (whether or not the **Insured** knew of such untruthful disclosure in the **Application**) or to whom knowledge of such facts is imputed, and (ii) any **Organization** to the extent it indemnifies an **Insured Person** who had knowledge of such facts or to whom knowledge of such facts is imputed, whether or not knowledge of such facts is also imputed to such **Organization**. For purposes of the preceding sentence, knowledge shall be imputed as follows:

    (a) the knowledge of any **Insured Person** who is a past, present or future chief financial officer, in-house general counsel, chief executive officer, president or chairperson, chief compliance officer, director of human resources, or medical director of any **Organization** shall be imputed to such **Organization** and its **Subsidiaries** and their respective **Plans**;

    (b) the knowledge of the person(s) who signed the **Application** for this coverage section shall be imputed to all of the **Insureds**; and

    (c) except as provided in (a) above, the knowledge of an **Insured Person** who did not sign the **Application** shall not be imputed to any other **Insured**.

Compliance With Applicable Trade Sanction Laws

20. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit the Company from providing insurance.

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 1

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

HEALTH CARE PORTFOLIO FIDUCIARY AMENDATORY ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) The term **Employee**, as defined in Subsection 3. Definitions, of this coverage section, is amended to include any leased or seasonal employee of the **Organization** or any **Plan**.

(2) The term **Fiduciary Claim**, as defined in Subsection 3. Definitions, of this coverage section, is amended to include a written demand for non-monetary relief, against an **Insured** for a **Wrongful Act**, including any appeal therefrom, commenced by the first receipt of such demand by an **Insured**.

(3) Exclusion 4(d) of this coverage section is deleted and replaced with the following:

(d) for bodily injury, mental anguish, emotional distress, humiliation, sickness, disease or death of any person or damage to or destruction of any tangible property including loss of use thereof whether or not it is damaged or destroyed;

(4) Exclusion 4(i) of this coverage section is deleted in its entirety.

(5) Exclusion 4(k) of this coverage section is deleted in its entirety.

(6) Exclusion 4(l) of this coverage section is deleted in its entirety.

(7) Subparagraph (a)(i) of Subsection 10. Reporting and Notice, of this coverage section, is deleted and replaced with the following:

(i) if this coverage section expires (or is otherwise terminated) without being renewed with the Company and if no Extended Reporting Period is purchased, sixty (60) days after the effective date of such expiration or termination; or

(8) Subsection 13. Other Insurance, of this coverage section, is amended as follows:

(A) The reference to “valid insurance” in the first sentence of this Subsection 13 is replaced with “valid and collectible insurance”.

(B) The last sentence is deleted and replaced with the following:

Any payment by **Insureds** of a retention or deductible under such other insurance shall reduce, by the amount of such payment which would otherwise be covered under this coverage section, the applicable Retention under this coverage section.

(9) The following Subsection is added to this coverage section:

Coordination with Employment Practices Liability Coverage Section

Any **Loss** otherwise covered by both (i) this coverage section and (ii) any employment practices liability coverage section or policy issued by the Company or by any affiliate of the Company (an "Employment Practices Liability Coverage"), first shall be covered as provided in, and shall be subject to the limit of liability, retention and coinsurance percentage applicable to the Employment Practices Liability Coverage. Any remaining **Loss** otherwise covered by this coverage section which is not paid under the Employment Practices Liability Coverage shall be covered as provided in, and shall be subject to the Limit of Liability and Retention applicable to this coverage section; provided the Retention applicable to such **Loss** under this coverage section shall be reduced by the amount of **Loss** otherwise covered by this coverage section which is paid by the **Insureds** as the retention under such Employment Practices Liability Coverage.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 2

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

WAIVER OF RECOURSE ENDORSEMENT

In consideration of the premium charged, it is agreed that the Company hereby expressly waives its right of recourse against the **Insured** under Section 410(b)(1) of **ERISA**, as amended.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 3

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

HIPAA CIVIL MONEY PENALTIES ENDORSEMENT

In consideration of the premium charged, it is agreed that:

1. The definition of **Loss** in Subsection 3 of this coverage section is amended by adding the following exception to subparagraph (d):

   (iv) any civil money penalties imposed upon an **Insured** for violation of Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), amendments to such law or regulations promulgated under such law concerning privacy of health information; provided the Company's maximum aggregate liability for all such civil money penalties on account of all **Claims** first made during the **Policy Period** shall be $100,000.00, which amount shall be part of, and not in addition to, the Company's maximum aggregate Limit of Liability set for in Item 3(C) of the Declarations for this coverage section.

2. No Retention shall apply to **Loss** constituting civil money penalties imposed upon an **Insured** for violation of Title II of HIPAA, amendments to such law or regulations promulgated under such law concerning privacy of health information.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 4

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

MULTI-EMPLOYER PLAN ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) Subsection 3 Definitions of this coverage section is amended to include the following:

> **Multiemployer Plan** means any multiemployer plan, as defined by **ERISA**, which is operated jointly by the **Organization** and one or more other employers or labor organizations for the benefit of the employees of the **Organization** among others.

(2) Solely with respect to **Claims** against a **Multiemployer Plan** or its **Insureds**, the definition of **Wrongful Act** in the Definitions, is amended to read in its entirety as follows:

> **Wrongful Act** means any negligent act, error or omission by the **Organization** or its past, present or future directors, officers or employees in the **Administration** of the **Multiemployer Plan** for the benefit of the employees of the **Organization**. Such coverage shall not extend to any **Multiemployer Plan** or any **Insured** in the capacity as a fiduciary of any **Multiemployer Plan**.

(3) When used in this coverage section, the term **Plan** is deemed to include any **Multiemployer Plan**, but only with respect to:

(a) The terms **Administration** and **Loss** as defined in Subsection 3 Definitions of this coverage section;

(b) The Exclusions set forth in Subsections 4 and 5 of this coverage section;

(c) Subsection 17 Termination of Plan of this coverage section; and

(d) Subsection 19 Representations and Severability of this coverage section.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 5

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

PRIORITY OF PAYMENTS

In consideration of the premium charged, it is agreed that with respect to any **Fiduciary Claim** first made against the **Insureds** during the **Policy Period**, regardless of whether such **Fiduciary Claim** is first made before or after the effective date of this endorsement:

1. If a liquidation or reorganization proceeding is commenced by or against the **Organization** pursuant to the United States Bankruptcy Code or any similar state or local law and in the event payment of **Loss** is due under this coverage section but, in the sole discretion of the Company, the amount of such **Loss** in the aggregate potentially exceeds the remaining available Limit of Liability for this coverage section, the Company shall:

   (a) first pay such covered **Loss** incurred by the **Insured Persons** and the **Plans**; then

   (b) to the extent of any remaining amount of the Limit of Liability available after payment under (a) above, pay such covered **Loss** incurred by the **Organization**.

Except as otherwise provided in this endorsement, the Company may pay covered **Loss** as it becomes due under this coverage section without regard to the potential for other future payment obligations under this coverage section.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 6

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND DEFINITION OF FIDUCIARY CLAIM ENDORSEMENT

In consideration of the premium charged, it is agreed that the term "**Fiduciary Claim**" as defined in Subsection 3., Definitions, of this coverage section is amended to include a written demand for arbitration proceeding commenced by receipt of a demand for arbitration or similar document against any **Insured** for a **Wrongful Act**, including any appeal therefrom.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 7

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTIONS 8 AND 15 TO REMOVE FINANCIAL IMPAIRMENT PROVISIONS ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) Subsection 8, Extended Reporting Period, of this coverage section is amended to delete the reference to the term "**Financial Impairment** event" contained in such Subsection.

(2) Subparagraph (c) of Subsection 15 of this coverage section is deleted in its entirety. All other references to the term **Financial Impairment** in Subsection 15 are deleted in their entirety.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 8

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND FIDUCIARY CLAIM ENDORSEMENT

In consideration of the premium charged, it is agreed that the term **Fiduciary Claim** as defined in Subsection 3, Definitions, of this coverage section is amended by adding the following subparagraph:

> **Fiduciary Claim** shall include a written request received by an **Insured** to toll or waive a statute of limitations relating to a potential **Fiduciary Claim** as described in (a) through (e) above.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 9

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND DEFINITION OF ORGANIZATION ENDORSEMENT

In consideration of the premium charged, it is agreed that the term **Organization**, as defined in Subsection 3, Definitions, of this coverage section, is deleted and replaced with the following:

> **Organization** means the **Parent Organization** and any **Subsidiary**, including any such organization in its capacity as a debtor in possession under the United States bankruptcy law or in an equivalent status under the law of any other country. **Organization** shall also include any **Affiliate** added as an affiliate by specific written endorsement to the General Terms and Conditions Section of this policy.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 10

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTION 13 OTHER INSURANCE ENDORSEMENT

In consideration of the premium charged, it is agreed that Subsection 13 Other Insurance of this coverage section is deleted and replaced with the following:

13. If any **Loss** under this coverage section is insured under any other valid and collectible insurance policy(ies), then this coverage section shall cover such **Loss**, subject to its limitations, conditions, provisions and other terms, only to the extent that the amount of such **Loss** is in excess of the applicable retention or deductible and limit of liability under such other insurance, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise, unless such other insurance is written only as specific excess insurance over the Limits of Liability provided in this coverage section. Any payment by **Insureds** of a retention or deductible under such other insurance shall not reduce, by the amount of such payment which would otherwise have been covered under this coverage section, the applicable Retention under this coverage section.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 11

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTION 6 SEVERABILITY OF EXCLUSIONS ENDORSEMENT

In consideration of the premium charged, it is agreed that:

Subparagraph (b) of Subsection 6 Severability of Exclusions of this coverage section is deleted and replaced with the following:

(b) Only facts pertaining to and knowledge possessed by any past, present, or future chief financial officer, in-house general counsel, chief executive officer, president or chief compliance officer of an **Organization** or **Plan** shall be imputed to such **Organization** or **Plan** for the purpose of applying the exclusion set forth in Subsection 4(m) of this coverage section.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 12

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTION 19 REPRESENTATIONS AND SEVERABILITY ENDORSEMENT

In consideration of the premium charged, it is agreed that:

The second full paragraph of Subsection 19. Representations and Severability of this coverage section is deleted and replaced with the following:

In the event that any of the statements, representations or information in the **Application** are not true and accurate, this coverage section shall be void with respect to (i) any **Insured** who knew the facts in the **Application** that were not truthfully and accurately disclosed (whether or not the **Insured** knew of such untruthful disclosure in the **Application**) or to whom knowledge of such facts is imputed, and (ii) any **Organization** to the extent it indemnifies an **Insured Person** who had knowledge of such facts or to whom knowledge of such facts is imputed, whether or not knowledge of such facts is also imputed to such **Organization**. For purposes of the preceding sentence, knowledge shall be imputed as follows:

(a) the knowledge of any **Insured Person** who is a past, present or future chief financial officer, in-house general counsel, chief executive officer, president or chief compliance officer of an **Organization** shall be imputed to such **Organization** and its **Subsidiaries** and their respective **Plans**;

(b) the knowledge of the person(s) who signed the **Application** for this coverage section shall be imputed to all **Organizations** and **Plans**; and

(c) no knowledge of any **Insured Person** shall be imputed to any other **Insured Person**.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 13

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND EXCLUSION 4(M) ENDORSEMENT

In consideration of the premium charged, it is agreed that:

Subparagraph (i) of Exclusion 4(m) of this coverage section is deleted and replaced with the following:

(i) the committing in fact of any deliberately fraudulent act or omission or any willful violation of any statute or regulation by such **Insured**, if a judgment or other final adjudication establishes such a deliberately fraudulent act or omission or willful violation of any statute or regulation; or

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 14

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND BENEFITS DUE EXCLUSION ENDORSEMENT

In consideration of the premium charged, it is agreed that paragraph (b) of Subsection 5, Exclusions, of this coverage section is amended to read in its entirety as follows:

(b) which constitutes (i) benefits due or to become due under any **Plan**, or (ii) benefits which would be due under any **Plan** if such **Plan** complied with all applicable law, including but not limited to **Loss** resulting from the payment of plaintiff attorneys' fees based upon a percentage of such benefits or payable from a common fund established to pay such benefits, except to the extent that:

(A) an **Insured** is a natural person and the benefits are payable by such **Insured** as a personal obligation, and recovery for the benefits is based upon a covered **Wrongful Act**; or

(B) a **Fiduciary Claim** made against an **Insured** alleges a loss to the **Plan** and/or to the accounts of such **Plan's** participants by reason of a change in the value of the investments held by such **Plan**, regardless of whether the amounts sought or recovered by the plaintiffs in such **Fiduciary Claim** are characterized by plaintiffs as "benefits" or held by a court as "benefits"; or

In the event that this endorsement conflicts with any other endorsement to this coverage section, this endorsement shall govern.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 15

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

PPA CIVIL MONEY PENALTIES ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) The term **Loss** as defined in Subsection 3, Definitions, of this coverage section is amended by adding the following exception to subparagraph (d):

> any civil money penalties imposed upon an **Insured** for violation of Section 507 of Title V of the Pension Protection Act of 2006 (the "PPA"); provided the Company's maximum aggregate liability for all such civil money penalties on account of all **Claims** first made during the **Policy Period** shall be twenty-five thousand dollars ($25,000), which amount shall be part of, and not in addition to, the Company's maximum aggregate Limit of Liability set forth in Item 3 of the Declarations for this coverage section;

(2) No retention shall apply to **Loss** constituting civil money penalties imposed upon an **Insured** for violation of Section 507 of Title V of the PPA.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 16

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

CLASS ACTION CLAIMS RETENTION ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) Subsection (A) of Item 4. Retentions, of the Declarations for this coverage section is deleted and replaced with the following:

(A) (i) Insuring Clause 1 – Fiduciary Liability Coverage:
for a **Non-Class Action**: $50,000.00

(ii) Insuring Clause 1 – Fiduciary Liability Coverage:
for a **Class Action**: $1,000,000.00

(2) Subsection 9. Limit of Liability and Retention, of this coverage section is amended to add the following paragraph to Paragraph (d) as follows:

If at any time a **Claim** ceases to be a **Class Action**, and becomes a **Non-Class Action**, the Retention applicable to such **Claim** shall be the amount set forth in Item 4(A)(i) of the Declarations for this coverage section, as amended in paragraph (1) of this Endorsement; however, no Retention borne by the **Insureds** while the **Claim** was a **Class Action** will be reimbursed or indemnified by the Company. If at any time a **Claim** ceases to be a **Non-Class Action**, and becomes a **Class Action**, the Retention applicable to such **Claim** shall be the amount set forth in Item 4(A)(ii) of the Declarations for this coverage section, as amended in paragraph (1) of this Endorsement.

(3) Subsection 3. Definitions, of this coverage section is amended to add the following definitions:

Class Action means any **Claim** brought or maintained:

(a) by or on behalf of five or more natural persons who are acting in concert, whether or not such natural persons are represented by one or more legal counsel;

(b) by or on behalf of one to four natural persons if any of such natural persons are seeking monetary relief on behalf of a class or group of complainants in order to resolve such **Claim**, whether or not such natural persons are represented by one or more legal counsel; or

(c) by a governmental entity, department or agency seeking monetary relief on behalf of a class or group of complainants in order to resolve such **Claim**.

Non-Class Action means any **Claim**, other than a **Class Action**.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio Fiduciary Liability Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 17

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

DELETE REVERSION OF ASSETS EXCLUSION ENDORSEMENT

In consideration of the premium charged, it is agreed that Subparagraph (a) of Section 5, Exclusions, of this coverage section is deleted in its entirety.

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

Notice of Loss Control Services

Insuring Company: Federal Insurance Company

As a Chubb policyholder, there is valuable loss prevention information available to you. Chubb designs comprehensive risk management services to accurately fit a client's specific risk needs. Consequently, since the needs of different types of health care organizations vary, our risk management activities are flexible enough to adapt to specific client characteristics. Many of these "value-added" services are available to our clients at no additional fee. Below is a description of these services.

Employment Practices Liability (EPL) Loss Prevention Services

- **Chubb EPL Loss Prevention Web Site**
  For information about the program, as well as a way to access many of our available services, go to http://csi.chubb.com/epllossprevention.

- **ChubbWorks.com**
  ChubbWorks.com is a web-based platform that offers multiple services including overviews of employment laws, sample employment policies and procedures, and on-line training. To gain immediate access to ChubbWorks go to **www.chubbworks.com** and register using your policy number.

- ***Employment Practices Loss Prevention Guidelines* Manual**
  Written by Seyfarth Shaw exclusively for Chubb, these two manuals provide overviews of key employment issues for either private or not-for-profit corporations and offer proactive ideas for avoiding employment lawsuits. To order the *Employment Practices Loss Prevention Guidelines* (geared toward private corporations), simply call **1.866.282.9001,** order 14-01-0061, and provide your mailing address. To order the *Employment Practices Loss Prevention Guidelines for Not-For-Profit Organizations,* simply call **1.866.282.9001,** order 14-01-0107, and provide your mailing address.

- **Loss Prevention Consultant Services**
  Chubb has developed a network of more than 120 law firms, human resources consulting firms, and labor economist/statistical firms that offer specialized services for employment issues. In addition to preferred rates for customers, Chubb will reimburse customers for 50% of the cost of the qualified services, up to 10% of the customer's insurance premium. To access the network of consultants and learn more about the consultant services program, go to Chubb's EPL Loss Prevention Web site at http://csi.chubb.com/epllossprevention.

- **Toll-free Hot Line**
  Have a question on how to handle an employment situation? Simply call **1.888.249.8425** to access the nationally known employment law firm of Jackson Lewis Schnitzler & Krupman. We offer customers an unlimited number of calls to the hot line at no additional charge.

If you have any questions on the EPL Loss Prevention program, simply consult http://csi.chubb.com/epllossprevention or email csi-info@chubb.com.

Directors and Officers (D&O) Liability Loss Prevention Services

- ***Directors and Officers Liability Loss Prevention*** **Manual**
  Written by Dan A. Bailey exclusively for Chubb, *Directors and Officers Liability Loss Prevention* discusses general principles governing D&O liability and potential exposures for directors and officers. To order *Directors and Officers Liability Loss Prevention,* simply call **1.866.282.9001,** order 14-01-0035, and provide your mailing address.

- **Basic Risk Management Series**-- ***Workplace Harassment: Awareness and Prevention***
  Even routine tasks can become overwhelming without a few reminders along the way. These easy-to-use informational brochures provide assistance with everyday topics, such as *Workplace Harassment: Awareness and Prevention*. To order *Workplace Harassment Awareness and Prevention,* simply call **1.866.282.9001,** order 14-01-0617, and provide your mailing address

- **Video Lending Library**
  We encourage client risk managers and their staff to borrow educational videos from our risk management video lending library for use in staff training.

Fiduciary Liability Loss Prevention Services

- ***Fiduciary Liability Loss Prevention*** **Manual**
  Written by Dan A. Bailey exclusively for Chubb, *Fiduciary Liability Loss Prevention* discusses general principles governing D&O liability and potential exposures for directors and officers. To order *Fiduciary Liability Loss Prevention,* simply call **1.866.282.9001,** order 14-01-0039, and provide your mailing address.

Crime Loss Prevention Services

- **Crime Loss Prevention Manual**
  Written by KPMG LLP exclusively for Chubb, the Crime Loss Prevention Manual discusses general principles governing workplace crime exposures. To order the Crime Loss Prevention Manual, simply call **1.866.282.9001,** order 14-01-0044, and provide your mailing address.

Kidnap/Ransom & Extortion Loss Prevention Services

- **Kidnap/Ransom & Extortion Loss Prevention Manuals**
  Chubb offers *Managing Terrorism Risks* and *Managing Travel Risks*, written exclusively for Chubb by the Ackerman Group, Inc., an international security consultant. To order the *Managing Terrorism Risks*, simply call **1.866.282.9001,** order 14-01-0179, and provide your mailing address. To order the *Managing Travel Risks*, simply call **1.866.282.9001,** order 14-01-0178, and provide your mailing address.

The services provided are advisory in nature. While this program is offered as a resource in developing or maintaining a loss prevention program, you should consult competent legal counsel to design and implement your own program. No liability is assumed by reason of the services, access or information provided. All services are subject to change without notice.

Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio ***SM***
Crime Coverage Section

DECLARATIONS

Policy Number: 8224-0373

FEDERAL INSURANCE COMPANY
A stock insurance company, incorporated under the laws of Indiana, herein called the Company

READ THE ENTIRE POLICY CAREFULLY.

Item 1. **Parent Organization:** DAUGHTERS OF CHARITY HEALTH SYSTEM
26000 ALTAMONT ROAD
LOS ALTOS HILLS, CA 94022

Item 2. Insuring Clauses:		Limits of Liability:
(A)	Insuring Clause 1 - Employee Theft Coverage:	$10,000,000.00
(B)	Insuring Clause 2 - Premises Coverage:	$10,000,000.00
(C)	Insuring Clause 3 - In Transit Coverage:	$10,000,000.00
(D)	Insuring Clause 4 - Forgery Coverage:	$10,000,000.00
(E)	Insuring Clause 5 - Computer Fraud Coverage:	$10,000,000.00
(F)	Insuring Clause 6 - Funds Transfer Fraud Coverage:	$10,000,000.00
(G)	Insuring Clause 7 - Money Orders And Counterfeit Currency Fraud Coverage:	$10,000,000.00
(H)	Insuring Clause 8 - Credit Card Fraud Coverage:	$10,000,000.00
(I)	Insuring Clause 9 - Client Coverage:	$10,000,000.00
(J)	Insuring Clause 10 - Expense Coverage:	$25,000.00

Item 3. Retention: $100,000.00

In consideration of payment of the premium and subject to the Declarations, the General Terms and Conditions, and the limitations, conditions, provisions and other terms of this coverage section, the Company and the Insureds agree as follows:

Insuring Clauses

Employee Theft Coverage Insuring Clause 1

1. The Company shall pay the **Parent Organization** for direct loss of **Money**, **Securities** or **Property** sustained by an **Insured** resulting from **Theft** or **Forgery** committed by an **Employee** acting alone or in collusion with others.

Premises Coverage Insuring Clause 2

2. The Company shall pay the **Parent Organization** for direct loss sustained by an **Organization** resulting from:

   (a) the unlawful taking of **Money** or **Securities** committed by a **Third Party**; or

   (b) the actual destruction or disappearance of **Money** or **Securities**,

   within or from the **Premises** or **Banking Premises**.

   Coverage under this Insuring Clause shall also include:

   (i) direct loss of or damage to **Property** which results from **Robbery** or attempted **Robbery** within the **Premises**;

   (ii) direct loss of or damage to **Property** contained within any locked vault or safe which results from **Safe Burglary** or attempted **Safe Burglary** within the **Premises**;

   (iii) damage to a locked safe, cash drawer, cash box or cash register within the **Premises** by felonious entry or attempted felonious entry or loss by felonious abstraction of such container from within the **Premises**; and

   (iv) damage to the **Premises** which results from **Robbery** or **Safe Burglary**,

   committed by a **Third Party**.

In Transit Coverage Insuring Clause 3

3. The Company shall pay the **Parent Organization** for direct loss sustained by an **Organization** resulting from:

   (a) the unlawful taking of **Money** or **Securities** committed by a **Third Party**; or

   (b) the actual destruction or disappearance of **Money** or **Securities**,

   while **In Transit** or while temporarily within the home of an **Employee** or an **Organization**.

Coverage under this Insuring Clause shall also include:

(i) direct loss of or damage to **Property** which results from **Robbery** while **In Transit**; and

(ii) direct loss which results from the unlawful taking of **Property** temporarily within the home of an **Employee** or an **Organization**,

committed by a **Third Party**.

Forgery Coverage Insuring Clause 4

4. The Company shall pay the **Parent Organization** for direct loss sustained by an **Organization** resulting from **Forgery** or alteration of a **Financial Instrument** committed by a **Third Party**, including:

   (a) any check or draft made or drawn in the name of such **Organization** payable to a fictitious payee and endorsed in the name of such fictitious payee;

   (b) any check or draft procured in a face to face transaction with such **Organization** or with one acting as the agent of such **Organization** by a **Third Party** impersonating another and made or drawn payable to the one impersonated and endorsed by a **Third Party** other than such one impersonated; and

   (c) any payroll check, payroll draft or payroll order made or drawn by such **Organization** payable to bearer as well as to a named payee and endorsed by a **Third Party** other than such named payee without the authority of such named payee.

Computer Fraud Coverage Insuring Clause 5

5. The Company shall pay the **Parent Organization** for direct loss of **Money**, **Securities** or **Property** sustained by an **Organization** resulting from **Computer Fraud** committed by a **Third Party**.

Funds Transfer Fraud Coverage Insuring Clause 6

6. The Company shall pay the **Parent Organization** for direct loss of **Money** or **Securities** sustained by an **Organization** resulting from **Funds Transfer Fraud** committed by a **Third Party**.

Money Orders And Counterfeit Currency Fraud Coverage Insuring Clause 7

7. The Company shall pay the **Parent Organization** for direct loss sustained by an **Organization** resulting from **Money Orders And Counterfeit Currency Fraud** committed by a **Third Party**.

Credit Card Fraud Coverage Insuring Clause 8

8. The Company shall pay the **Parent Organization** for direct loss sustained by an **Organization** resulting from **Credit Card Fraud** committed by a **Third Party**.

Client Coverage Insuring Clause 9

9. The Company shall pay the **Parent Organization** for direct loss of **Money**, **Securities** or **Property** sustained by a **Client** resulting from **Theft** or **Forgery** committed by an **Employee** not in collusion with such **Client's** employees.

Expense Coverage Insuring Clause 10

10. The Company shall pay the **Parent Organization** for:

    (a) **Investigative Expenses** resulting from any loss covered under Insuring Clauses 1 through 9 incurred by an **Organization**, but only if such covered loss under Insuring Clauses 1 through 9 is in excess of the Retention applicable to such covered loss;

    (b) **Computer Violation Expenses** resulting from any loss covered under Insuring Clause 1, 5 or 9 incurred by an **Organization**, but only if such covered loss under Insuring Clause 1, 5 or 9 is in excess of the Retention applicable to such covered loss.

    No Retention shall apply to **Investigative Expenses** or **Computer Violation Expenses** covered under Insuring Clause 10.

Definitions

11. When used in this coverage section:

    Application means all signed applications, including attachments and other materials submitted therewith or incorporated therein, submitted by the **Insureds** to the Company for this coverage section or for any coverage section or policy of which this coverage section is a direct or indirect renewal or replacement. **Application** shall also include, for each **Insured**, all documents provided by the **Insureds** to the Company in connection with the underwriting or issuance of this coverage section. All such applications, attachments, materials and other documents are deemed attached to, incorporated into and made a part of this coverage section.

    Banking Premises means the interior portion of a building occupied by, or the night depository chute or safe maintained by, any bank, trust company or similar financial institution.

    Client means a customer of an **Organization** to whom such **Organization** provides goods or services under written contract or for a fee.

    Computer Fraud means the unlawful taking or the fraudulently induced transfer of **Money**, **Securities** or **Property** resulting from a **Computer Violation**.

Computer System means a computer and all input, output, processing, storage, off-line media library and communication facilities which are connected to such computer, provided that such computer and facilities are owned and operated or leased and operated by an **Organization**.

Computer Violation means the fraudulent:

(a) entry of **Data** into or deletion of **Data** from a **Computer System**;

(b) change to **Data** elements or program logic of a **Computer System**, which is kept in machine readable format; or

(c) introduction of instructions, programmatic or otherwise, which propagate themselves through a **Computer System**,

directed against an **Organization**.

Computer Violation Expenses means reasonable expenses, other than an **Organization's** internal corporate costs (such as **Salary**), incurred by an **Organization**, with the Company's prior written consent, to reproduce or duplicate damaged or destroyed **Data** or computer programs. If such **Data** or computer programs cannot be duplicated from other **Data** or computer programs, then **Computer Violation Expenses** shall also include reasonable costs incurred for computer time, computer programmers, technical experts or consultants to restore such **Data** or computer programs to substantially the same level or operational capability existing immediately before the covered loss. **Computer Violation Expenses** shall not include expenses incurred by any **Client**.

Credit Card Fraud means the **Forgery** or alteration of, on or in any written instrument required in connection with any credit card issued to an **Organization** or, at the request of an **Organization**, to an **Employee**.

Data means a representation of information, knowledge, facts, concepts or instructions which are processed and stored in a **Computer System**.

Discovery or **Discovered** means an **Executive** or **Insurance Representative** has become aware of facts which would cause a reasonable person to assume that a loss of a type covered by this coverage section has occurred or acts have taken place that may subsequently result in a loss of a type covered by this coverage section. This includes loss:

(a) sustained prior to the inception date of any coverage under this coverage section;

(b) which is within the applicable Retention as set forth in Item 3 of the Declarations for this coverage section; or

(c) for which the exact amount or details are unknown.

Discovery or **Discovered** shall not include knowledge acquired by an **Executive** or **Insurance Representative** acting alone in a **Theft** or **Forgery**, or acting in collusion with any **Employee** in a **Theft** or **Forgery**.

Employee means any:

(a) natural person while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whom such **Organization** compensates by **Salary** and has the right to govern and direct in the performance of such service, including any part-time, seasonal, leased or temporary employee;

(b) natural person volunteer while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whom such **Organization** has the right to govern and direct in the performance of such service;

(c) **Executive** while performing acts within the scope of the usual duties of an **Employee**; or

(d) natural person fiduciary, trustee, administrator or other plan official, while in the regular service of an **ERISA Plan**, who is required to be bonded by an **Organization** in connection with such **ERISA Plan** by Title 1 of the Employee Retirement Income Security Act of 1974, as amended.

ERISA Plan means any Employee Benefit Plan, Pension Benefit Plan, or Welfare Benefit Plan, defined and required to be bonded under Title 1 of the Employee Retirement Income Security Act of 1974, as amended, which is operated solely by an **Organization** or jointly by an **Organization** and a labor organization for the benefit of **Employees** and which existed on or before the inception of this coverage section or which is created or acquired after the inception of this coverage section.

Executive means any natural person specified below:

(a) duly elected or appointed director, officer, member of the Board of Managers or management committee member of an **Organization** chartered in the United States of America;

(b) in–house general counsel of an **Organization** chartered in the United States of America;

(c) equivalent positions of (a) or (b) above in an **Organization** chartered in any other jurisdiction anywhere in the world; or

(d) a partner of an **Organization** while engaged in the regular service of such **Organization**.

Financial Instrument means a check, draft or similar written promise, order or direction to pay a sum certain in **Money** that is made, drawn by or drawn upon an **Organization** or made or drawn by anyone acting as an **Organization's** agent, or that is purported to have been so made or drawn.

Forgery means the signing of the name of another natural person or organization, with the intent to deceive, but does not mean a signature that includes, in whole or in part, one's own name, with or without authority, in any capacity for any purpose. Mechanically or electronically produced or reproduced signatures shall be treated the same as hand-written signatures.

Funds Transfer Fraud means fraudulent electronic, telegraphic, cable, teletype, facsimile, telephone or written instructions (other than **Forgery**), purportedly issued by an **Organization**, and issued to a financial institution directing such institution to transfer, pay

or deliver **Money** or **Securities** from any account maintained by such **Organization** at such institution, without such **Organization's** knowledge or consent.

Insurance Representative means any **Employee**, including a risk manager, designated to represent an **Insured** for the purpose of effecting and maintaining insurance.

Insured means any **Organization** and, for the purposes of Insuring Clause 1, any **ERISA Plan** or **Non-ERISA Plan**.

In Transit means being conveyed outside the **Premises**, from one person or place to another, by an **Organization** within the custody of:

(a) an **Employee**; or

(b) a person duly authorized by such **Organization** to have custody of such **Money**, **Securities** or **Property**.

Such conveyance begins immediately upon receipt of **Money**, **Securities** or **Property** by the person(s) described in (a) or (b) above from such **Organization**, and ceases immediately upon delivery to the designated recipient or its agent.

Investigative Expenses means reasonable expenses, other than an **Organization's** internal corporate costs (such as **Salary**), incurred by an **Organization**, with the Company's prior written consent, to establish the existence and amount of a covered loss. **Investigative Expenses** shall not include expenses incurred by any **Client**.

Money means currency, coin, bank notes and bullion.

Money Orders And Counterfeit Currency Fraud means the good faith acceptance by an **Organization**:

(a) in exchange for merchandise, **Money** or services, of any post office or express money order, issued or purporting to have been issued by any post office or express company, if such money order is not paid upon presentation; or

(b) in the regular course of business, of counterfeit United States of America or Canadian paper currency.

Non-ERISA Plan means any employee benefit plan not subject to Title 1 of the Employee Retirement Income Security Act of 1974, as amended, which is operated solely by an **Organization** or jointly by an **Organization** and a labor organization for the benefit of **Employees** and which existed on or before the inception of this coverage section or which is created or acquired after the inception of this coverage section.

Organization means the **Parent Organization** and any **Subsidiary**. **Organization** shall also include any **Affiliate** added as an affiliate by specific written endorsement to the General Terms and Conditions Section of this policy.

Premises means the interior portion of a building occupied by an **Organization** in conducting its business.

Property means tangible property other than **Money** or **Securities**.

Robbery means the unlawful taking of **Money**, **Securities** or **Property** from the custody of an **Employee**, or other person (except a person acting as a watchman, porter or janitor) duly authorized by an **Organization** to have custody of such **Money**, **Securities** or **Property**, by violence or threat of violence, committed in the presence and cognizance of such **Employee** or other person.

Safe Burglary means the unlawful taking of **Money**, **Securities** or **Property**, by forcible or violent entry evidenced by visible marks, from a locked vault or safe located within the **Premises**.

Salary means compensation an **Organization** pays an **Employee**, including bonus, commission, incentive payments, and the cost of health, welfare and pension benefits.

Securities means negotiable and non-negotiable instruments or contracts representing either **Money** or **Property**.

Theft means the unlawful taking of **Money**, **Securities** or **Property** to the deprivation of:

(a) an **Insured**, solely for the purposes of Insuring Clause 1; or

(b) a **Client**, solely for the purposes of Insuring Clause 9.

Third Party means a natural person other than:

(a) an **Employee**; or

(b) a natural person acting in collusion with an **Employee**.

Exclusions

12. No coverage will be available under this coverage section for:

(a) loss resulting directly or indirectly from any authorized or unauthorized trading of **Money**, **Securities** or **Property**, whether or not in the name of an **Insured** and whether or not in a genuine or fictitious account; provided that this Exclusion 12(a) shall not apply to otherwise covered loss under Insuring Clause 1 which results in improper financial gain to an **Employee** (such loss shall mean only the amount of improper financial gain to such **Employee**, and shall not include **Salary**, commissions, fees or other compensation, including but not limited to promotions and raises associated with employment, paid by the **Insured** to such **Employee**);

(b) loss of any trade secret, confidential processing method or other confidential information of any kind;

(c) loss due to **Theft** or **Forgery** committed by a partner of an **Organization**, whether acting alone or in collusion with others; provided that, if such **Theft** or **Forgery** would otherwise be covered under Insuring Clause 1 or 9, this Exclusion 12(c) shall not apply to the extent coverage under this coverage section is excess of the amount of such partner's percentage ownership of such **Organization**, on the day immediately preceding the date of **Discovery**, multiplied by such **Organization's** total assets as reflected in such **Organization's** most recent audited financial statements;

(d) loss or damage due to declared or undeclared war, civil war, insurrection, rebellion, revolution, military, naval or usurped power, governmental intervention, expropriation or nationalization, or any act or condition incident to any of the foregoing;

(e) loss or damage due to nuclear reaction, nuclear radiation or radioactive contamination, or any act or condition incident to any of the foregoing;

(f) loss of income not realized as the result of a covered loss;

(g) indirect or consequential loss or damage of any kind; provided that this Exclusion 12(g) shall not apply to otherwise covered **Investigative Expenses** and **Computer Violation Expenses** under Insuring Clause 10;

(h) fees, costs or expenses incurred or paid:

(i) as a result of the reconstitution of **Data** if an **Organization** knowingly used illegal copies of programs;

(ii) to render the **Data** usable by replacement processing equipment;

(iii) to design, update or improve software or programs or to perfect their operation or performance; or

(iv) as a result of an alteration in **Data** held on magnetic media due to the effect of magnetic fields, their incorrect use or the obsolescence of the computer or its facilities;

(i) fees, costs or expenses incurred or paid in defending or prosecuting any legal proceeding or claim; provided that this Exclusion 12(i) shall not apply to the coverage provided under Subsection 22 Legal Expenses Extension;

(j) loss or damage due to fire; provided that this Exclusion 12(j) shall not apply to:

(i) loss of **Money** or **Securities**; or

(ii) damage to any safe or vault caused by the application of fire thereto for the purposes of **Safe Burglary**;

(k) loss due to an **Insured** knowingly having given or surrendered **Money**, **Securities** or **Property** in any exchange or purchase with a **Third Party**; provided that this Exclusion 12(k) shall not apply to otherwise covered loss under Insuring Clause 7 or otherwise covered loss of **Property** under Insuring Clause 5;

(l) loss sustained by one **Insured** to the advantage of any other **Insured**;

(m) loss of or damage to **Money**, **Securities** or **Property** while in the custody of any bank, trust company, similar recognized place of safe deposit, armored motor vehicle company or any person who is duly authorized by an **Organization** to have custody of such **Money**, **Securities** or **Property**; provided that this Exclusion 12(m) shall not apply to the extent that coverage under this coverage section is excess of the amount recovered or received by such **Organization** under:

(i) such **Organization's** contract, if any, with, or insurance carried by, any of the foregoing; or

(ii) any other insurance or indemnity in force which would cover the loss in whole or in part; or

(n) loss or damage due to **Theft**, **Forgery**, **Computer Fraud**, **Funds Transfer Fraud**, **Money Orders And Counterfeit Currency Fraud**, **Credit Card Fraud** or other fraudulent, dishonest or criminal act (other than **Robbery** or **Safe Burglary**) committed by any authorized representative of an **Insured**, whether acting alone or in collusion with others; provided that this Exclusion 12(n) shall not apply to otherwise covered loss under Insuring Clause 1 or 9 resulting from **Theft** or **Forgery** committed by an **Employee** acting in collusion with such authorized representative.

13. No coverage will be available under Insuring Clause 1 or 9 for:

(a) loss caused by any agent, broker, factor, commission merchant, consignee, contractor, independent contractor, subcontractor or other similar representative; or

(b) loss caused by an **Employee** which is sustained by an **Insured**:

(i) after an **Executive** or **Insurance Representative** becomes aware of a **Theft**, **Forgery** or other fraudulent, dishonest or criminal act committed by such **Employee** while employed with or in the service of an **Insured**;

(ii) after an **Executive** or **Insurance Representative** becomes aware of a **Theft**, **Forgery** or other fraudulent, dishonest or criminal act, involving **Money**, **Securities** or other property valued at twenty-five thousand dollars ($25,000) or more, committed by such **Employee** prior to employment or service with an **Insured**; or

(iii) more than sixty (60) days following the termination of such **Employee**.

14. No coverage will be available under Insuring Clause 2 or 3 for:

(a) loss or damage due to **Forgery**, **Computer Fraud**, **Funds Transfer Fraud**, **Money Orders And Counterfeit Currency Fraud** or **Credit Card Fraud**; or

(b) loss of or damage to **Money**, **Securities** or **Property** while in the mail or in the custody of a carrier for hire other than an armored motor vehicle company.

15. No coverage will be available under Insuring Clause 2, 3, 5, or 6 for loss or damage as a result of a kidnap, ransom or other extortion payment (as distinct from **Robbery**) surrendered to any person as a result of a threat to do bodily harm to any person or a threat to do damage to any property.

16. No coverage will be available under Insuring Clause 4 for loss due to **Forgery** or alteration of any registered or coupon obligation issued or purported to have been issued by an **Insured**, or any coupon whether attached or detached.

17 No coverage will be available under Insuring Clause 5 for loss caused by a **Third Party** which is sustained by an **Organization** sixty (60) days or more after an **Organization** becomes aware of a **Computer Fraud** or other fraudulent, dishonest or criminal act committed by such **Third Party**.

18. No coverage will be available under Insuring Clause 8 for loss caused by any forgery or alteration of, on or in any written instrument; provided that this Exclusion 18 shall not apply if:

    (a) the provisions, conditions and other terms under which the involved credit card was issued were fully complied with; and

    (b) an **Organization** is legally liable to the issuer of such credit card for such loss.

19. No coverage will be available under this coverage section for:

    (a) loss unless sustained by an **Insured** prior to the termination of this coverage section as to such **Insured**, and **Discovered** and written notice thereof is given to the Company within sixty (60) days following such termination;

    (b) loss unless sustained prior to the termination of any Insuring Clause or any particular coverage offered under any Insuring Clause, and **Discovered** and written notice thereof is given to the Company within sixty (60) days following such termination; or

    (c) loss unless sustained prior to the termination of this coverage section in its entirety, and **Discovered** and written notice thereof is given to the Company within sixty (60) days following such termination;

    provided that in no event will coverage be available under this coverage section for such loss if such loss is covered under any renewal or replacement of this coverage section or any Insuring Clause or any particular coverage offered under any Insuring Clause.

Ownership

20. Solely for the purposes of Insuring Clauses 1 through 8, the Company's liability under this coverage section will apply only to **Money**, **Securities** or **Property** owned by the **Organization** or for which the **Organization** is legally liable, or held by the **Organization** in any capacity whether or not the **Organization** is liable; provided that:

    (a) the Company's liability will not apply to damage to the **Premises** unless the **Organization** is the owner of such **Premises** or is legally liable for such damage; or

    (b) with respect to Insuring Clause 1, the Company's liability will not apply to **Money**, **Securities** or **Property** of a **Client**.

    Solely for the purposes of Insuring Clause 9, the Company's liability under this coverage section will apply only to **Money**, **Securities** or **Property** owned by a **Client**, which is held by the **Organization** in any capacity or for which the **Organization** is legally liable.

ERISA Plan

21. Solely with respect to loss sustained by an **ERISA Plan**, payment by the Company for covered loss to the **Parent Organization** shall be held by such **Parent Organization** for the use and benefit of the **ERISA Plan** sustaining such loss.

Solely with respect to loss sustained by an **ERISA Plan**:

(a) Insuring Clause 1 is amended to read in its entirety as follows:

The Company shall pay the **Parent Organization** for direct loss of **Money**, **Securities** or **Property** sustained by an **ERISA Plan** resulting from a fraudulent or dishonest act committed by an **Employee** acting alone or in collusion with others.

(b) The words "sixty (60) days" are deleted from Exclusion 19 of this coverage section, wherever they appear in such Exclusion, and the words "one (1) year" are substituted in place thereof.

No Retention shall apply to loss sustained by an **ERISA Plan** covered under this coverage section.

Legal Expenses Extension

22. In addition to the Limits of Liability set forth in the Declarations for this coverage section, the Company shall pay the **Parent Organization** for:

(a) As a result of loss covered under Insuring Clause 4, reasonable court costs and attorneys' fees incurred and paid, with the Company's prior written consent, in defending an **Organization** or an **Organization's** bank in any legal proceeding brought against it to enforce payment of a **Financial Instrument**;

(b) As a result of loss covered under Insuring Clause 8, reasonable court costs and attorneys' fees incurred and paid, with the Company's prior written consent, in defending an **Organization** in any legal proceeding brought against it to enforce payment of a written instrument, required in connection with any credit card.

Changes in Exposure

23. If before or during the **Policy Period** any **Organization**:

(a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or

(b) acquires another organization by merger into or consolidation with such **Organization** such that such **Organization** is the surviving entity,

then coverage shall be provided for such acquired organization or new **Subsidiary** after the effective date of such acquisition or creation.

If, at the time of any such acquisition or creation described above, the total revenues of any such acquired organization or new **Subsidiary** exceed ten percent (10%) of the total revenues of the **Parent Organization** (as reflected in the most recent audited consolidated financial statements of such organization and the **Parent Organization**, respectively, as of the date of such acquisition or creation), then the **Parent Organization** shall give written notice of such acquisition or creation to the Company as soon as practicable, but in no event later than sixty (60) days after the date of such acquisition or creation, together with such information as the Company in its sole discretion may require and shall pay any reasonable additional premium required by the Company. If the **Parent Organization** fails to give such notice within the time specified in the preceding sentence, or fails to pay the

additional premium required by the Company, coverage for such acquired organization or new **Subsidiary** shall be null and void from the date of such acquisition or creation. Coverage for such acquired organization or new **Subsidiary** shall be subject to such additional or different limitations, conditions, provisions or other terms as the Company in its sole discretion may require.

Liability For Prior Losses

24. In the event of loss sustained prior to the inception date of this coverage section, prior to the effective date of coverage for any additional insureds or prior to the effective date of any coverage added by endorsement, which would otherwise be covered under this coverage section, such prior loss shall be afforded coverage subject to the following:

    (a) an **Insured** or some predecessor in interest of such **Insured** carried a prior bond or policy, which at the time such prior loss was sustained, afforded some or all of the coverage of an Insuring Clause under this coverage section applicable to such prior loss;

    (b) such coverage continued without interruption from the time such prior loss was sustained until the inception date or effective date(s) as described above;

    (c) such prior loss was first **Discovered** by an **Insured** after the time allowed for discovery under the last such policy; and

    (d) some or all of the coverage of an Insuring Clause under this coverage section would be applicable to such prior loss.

    If such prior bond or policy carried by the **Insured** or predecessor in interest of such **Insured** was issued by the Company or its affiliates, such prior bond or policy shall terminate as of the inception of this coverage section and such prior bond or policy shall not cover any loss not discovered and noticed to the Company prior to the inception of this coverage section.

    The **Insured** shall neither be entitled to a separate recovery of the limits of each policy in force at the time any part of the prior loss was sustained, nor shall the **Insured** be entitled to recover the sum of the limits of liability of any such policies. The Company's maximum liability for such prior loss shall not exceed the lesser of the limit of liability of the policy in force at the time such prior loss was sustained, or the applicable Limit of Liability as set forth in the Declarations for this coverage section.

Limits of Liability and Retention

25. Subject to Subsection 24 Liability for Prior Losses, the Company shall only be liable for loss sustained by an **Insured** during the **Policy Period**.

    The Company's maximum liability for each loss shall not exceed the Limit of Liability applicable to such loss, as set forth in Item 2 of the Declarations for this coverage section, regardless of the number of **Insureds** sustaining such loss.

    The Company's maximum liability shall not exceed the Limit of Liability:

    (a) Applicable to Insuring Clause 1 as set forth in Item 2(A) of the Declarations for this coverage section: for all loss resulting from any act or any series of acts committed by the same **Employee** or in which the same **Employee** is concerned or implicated,

regardless of whether such act or series of acts was committed before or during the **Policy Period**;

(b) Applicable to Insuring Clause 2 as set forth in Item 2(B) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(c) Applicable to Insuring Clause 3 as set forth in Item 2(C) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(d) Applicable to Insuring Clause 4 as set forth in Item 2(D) of the Declarations for this coverage section: for all loss resulting from any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act or series of acts was committed before or during the **Policy Period**;

(e) Applicable to Insuring Clause 5 as set forth in Item 2(E) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(f) Applicable to Insuring Clause 6 as set forth in Item 2(F) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(g) Applicable to Insuring Clause 7 as set forth in Item 2(G) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(h) Applicable to Insuring Clause 8 as set forth in Item 2(H) of the Declarations for this coverage section: for all loss resulting from any act, casualty or event, any series of related acts, casualties or events, or any act or series of acts committed by the same **Third Party** or in which the same **Third Party** is concerned or implicated, regardless of whether such act, casualty or event or series of acts, casualties or events was committed or occurred before or during the **Policy Period**;

(i) Applicable to Insuring Clause 9 as set forth in Item 2(I) of the Declarations for this coverage section: for all loss resulting from any act or any series of acts committed by the same **Employee** or in which the same **Employee** is concerned or implicated, regardless of whether such act or series of acts was committed before or during the **Policy Period**; or

(j) Applicable to Insuring Clause 10 as set forth in Item 2(J) of the Declarations for this coverage section: for all **Investigative Expenses** or **Computer Violation Expenses** resulting from any applicable covered loss.

If a loss is covered under more than one Insuring Clause, the maximum amount payable under this coverage section shall not exceed the largest applicable Limit of Liability of any such Insuring Clause.

The Company's liability under this coverage section shall apply only to that part of each loss which is in excess of the applicable Retention set forth in Item 3 of the Declarations for this coverage section.

Non-Accumulation of Liability

26. When there is more than one **Insured**, the maximum liability of the Company for loss sustained by any or all **Insureds** shall not exceed the amount for which the Company would be liable if all loss was sustained by any one **Insured**.

Regardless of the number of years this coverage remains in effect and the total premium amounts due or paid, whether under this coverage section, any prior bond or policy, or any renewal or replacement of this coverage section, the liability of the Company with respect to any loss shall not be cumulative from year to year or from policy period to policy period.

Proof of Loss and Legal Proceedings

27. Knowledge possessed by any **Insured** or **Discovery** shall be deemed knowledge possessed by or discovery by all **Insureds**.

It is a condition precedent to coverage hereunder that, upon **Discovery**, the **Parent Organization** will:

(a) give written notice to the Company at the earliest practicable moment, and in no event later than ninety (90) days after such **Discovery**;

(b) furnish affirmative proof of loss with full particulars to the Company at the earliest practicable moment**,** and in no event later than six (6) months after such **Discovery**;

(c) submit to examination under oath at the Company's request;

(d) produce all pertinent records at such reasonable times and places as the Company shall designate; and

(e) provide full cooperation with the Company in all matters pertaining to a loss or claim.

The **Parent Organization** may not offer, as a part of any proof of loss, any computation or comparison which involves in any manner a profit and loss computation or comparison. The **Parent Organization** may offer a comparison between an **Organization's** or **Client's** inventory records and actual physical count of its inventory to prove the amount of loss, only where an **Organization** or **Client** establishes wholly apart from such comparison that it has sustained a covered loss caused by an identified **Employee**.

No **Insured** shall institute legal proceedings against the Company:

(a) after two (2) years immediately following any **Discovery**; or

(b) to recover a judgment or settlement against it or its bank resulting from **Forgery**, **Credit Card Fraud** or related legal expenses as set forth in Subsection 22 Legal Expenses Extension, after two (2) years immediately following the date upon which such judgment shall become final or settlement was entered.

Valuation and Foreign Currency

28. The Company shall pay:

(a) the least of:

(i) the actual market value of lost, damaged or destroyed **Securities** at the closing price of such **Securities** on the business day immediately preceding the day on which a loss is **Discovered**;

(ii) the cost of replacing **Securities**; or

(iii) the cost to post a Lost Instrument Bond;

(b) the cost of blank books, pages or tapes or other blank materials to replace lost or damaged books of account or other records;

(c) the least of:

(i) the actual cash value of **Property**; or

(ii) the cost to repair or replace **Property**, other than precious metals, with that of similar quality and value,

at the time the **Parent Organization** complies with Subsection 27 Proof of Loss and Legal Proceedings, regarding the furnishing of proof of loss;

(d) the United States of America dollar value of foreign currency based on the rate of exchange published in *The Wall Street Journal* on the day loss involving foreign currency is **Discovered**; or

(e) the United States of America dollar value of any precious metal based on the amount published in *The Wall Street Journal* Cash Prices, Precious Metals, on the day loss involving such precious metal is **Discovered**.

Recoveries

29. Recoveries for any loss covered under this coverage section, whether effected by the Company or by an **Insured**, less the cost of recovery, shall be distributed as follows:

(a) first, to an **Insured** for the amount of such loss, otherwise covered, in excess of the applicable Limits of Liability;

(b) second, to the Company for the amount of such loss paid to an **Insured** as covered loss;

(c) third, to an **Insured** for the Retention applicable to such loss;

(d) fourth, to an **Insured** for the amount of such loss not covered under this coverage section.

Recovery from reinsurance or indemnity of the Company shall not be deemed a recovery hereunder.

Other Insurance

30. If any **Insured** or any other party in interest in any loss covered by this coverage section has any bond, indemnity or insurance which would cover such loss in whole or in part in the absence of this coverage section, then this coverage section shall be null and void to the extent of the amount recoverable or received under such bond, indemnity, or insurance; provided that this coverage section shall cover such loss, subject to its limitations, conditions, provisions and other terms, to the extent of the amount of such loss in excess of the amount recoverable or received under such bond, indemnity or insurance.

Compliance With Applicable Trade Sanction Laws

31. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit the Company from providing insurance.

ENDORSEMENT

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 1

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND DEFINITION OF EXECUTIVE ENDORSEMENT

In consideration of the premium charged, it is agreed that subparagraph (a) of the term **Executive** as defined in Subsection 11 Definitions of this coverage section is amended to read in its entirety as follows:

(a) duly elected or appointed director, officer, trustee, member of the Board of Managers or management committee member of an **Organization** chartered in the United States of America;

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 2

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND SUBSECTION 28(c) VALUATION AND FOREIGN CURRENCY ENDORSEMENT

In consideration of the premium charged, it is agreed that subparagraph (c) of Subsection 28, Valuation and Foreign Currency, of this coverage section is amended to read in its entirety as follows:

(c) the cost to repair or replace **Property**, other than precious metals, with that of similar quality and value at the time the **Parent Organization** complies with Subsection 27 Proof of Loss and Legal Proceedings, regarding the furnishing of proof of loss;

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 3

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND DEFINITION OF EMPLOYEE TO INCLUDE NON-COMPENSATED EMPLOYEES ENDORSEMENT

In consideration of the premium charged, it is agreed that the Definitions of "Employee" of Subsection 11. Definitions is deleted and replaced with the following:

Employee means any:

(a) natural person while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whether or not compensated, whom such **Organization** has the right to govern and direct in the performance of such service, including any part-time, seasonal, leased or temporary employee;

(b) natural person volunteer while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whom such **Organization** has the right to govern and direct in the performance of such service;

(c) **Executive**, whether or not compensated, while performing acts within the scope of the usual duties of an **Employee**; or

(d) natural person fiduciary, trustee, administrator or other plan official, while in the regular service of an **ERISA Plan**, who is required to be bonded by an **Organization** in connection with such **ERISA Plan** by Title 1 of the Employee Retirement Income Security Act of 1974, as amended.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 4

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

CONVERSION ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) Subsection 19, Exclusions, of this coverage section is amended to read in its entirety as follows:

19. No coverage will be available under this coverage section for:

(a) loss unless sustained by an **Insured** and **Discovered** prior to the termination of this coverage section as to such **Insured**;

(b) loss unless sustained and **Discovered** prior to the termination of any Insuring Clause or any particular coverage offered under any Insuring Clause; or

(c) loss unless sustained and **Discovered** prior to the termination of this coverage section in its entirety;

provided that in no event will coverage be available under this coverage section for such loss if such loss is covered under any renewal or replacement of this coverage section or any Insuring Clause or any particular coverage offered under any Insuring Clause issued by the Company or by any affiliate of the Company.

(2) The first paragraph of Subsection 23, Changes in Exposure, of this coverage section is amended to read in its entirety as follows:

If before or during the **Policy Period** any **Organization**:

(a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or

(b) acquires another organization by merger into or consolidation with such **Organization** such that such **Organization** is the surviving entity,

then coverage shall be provided for such acquired organization or new **Subsidiary** for loss **Discovered** after the effective date of such acquisition or creation.

(3) Subsection 24, Liability for Prior Losses, of this coverage section is deleted in its entirety. Accordingly, any and all references to Subsection 24 are deleted in their entirety

(4) The first paragraph of Subsection 25, Limits of Liability and Retention, of this coverage section is amended to read in its entirety as follows:

The Company shall only be liable for loss sustained by an **Insured** prior to termination of this coverage section and **Discovered** during the **Policy Period**.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 5

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

HEALTH CARE PORTFOLIO CRIME AMENDMENTS ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) The term **Computer System**, as defined in Subsection 11 Definitions of this coverage section, is amended to read in its entirety as follows:

Computer System means a computer and all input, output, processing, storage, off-line media library and communication facilities which are connected to such computer, provided that such computer and facilities are:

(a) owned and operated by an **Organization**;

(b) leased and operated by an **Organization**; or

(c) utilized by an **Organization**.

(2) The term **Employee**, as defined in Subsection 11 Definitions of this coverage section is amended to delete paragraph (a) and replace it with the following:

(a)(i) natural person while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whom such **Organization** compensates by **Salary** and has the right to govern and direct in the performance of such service, including any part-time or seasonal employee;

(ii) natural person while in the regular service of an **Organization** in the ordinary course of such **Organization's** business, whom such **Organization** has the right to govern and direct in the performance of such service and is assigned to perform such service by any agency furnishing leased personnel or temporary personnel on a contingent or part-time basis; provided that **Employee** shall not include such a natural person, and no coverage will be available under this coverage section for loss caused by such a natural person, if such loss is covered under any bond, indemnity or insurance held by the agency furnishing such personnel;

(3) The term **Money Orders And Counterfeit Currency Fraud**, as defined in Subsection 11 Definitions of this coverage section, is amended to read in its entirety as follows:

Money Orders And Counterfeit Currency Fraud means the good faith acceptance by an **Organization**:

(a) in exchange for merchandise, **Money** or services, of any post office or express money order, issued or purporting to have been issued by any post office or express company, if such money order is not paid upon presentation; or

(b) in the regular course of business, of counterfeit paper currency.

(4) The term **Securities**, as defined in Subsection 11 Definitions of this coverage section is amended to include revenue and other stamps in current use, tokens and tickets. **Securities** does not include **Money**.

(5) Exclusion 12(a) of this coverage section is deleted.

(6) No coverage will be available under Insuring Clause 1 or 9 of this coverage section for loss resulting directly or indirectly from any authorized or unauthorized trading of **Money**, **Securities** or **Property**, whether or not in the name of an **Insured** and whether or not in a genuine or fictitious account; provided that this Exclusion shall not apply to otherwise covered loss under Insuring Clause 1 or 9 which results in improper financial gain to an **Employee** (such loss shall mean only the amount of improper financial gain to such **Employee**, and shall not include **Salary**, commissions, fees or other compensation, including but not limited to promotions and raises associated with employment, paid by the **Insured** to such **Employee**).

(7) Subparagraph (h)(ii) of Exclusion 12 of this coverage section is amended to read in its entirety as follows:

(ii) to render **Data** usable by replacement processing equipment;

(8) Exclusion 12(j) of this coverage section is deleted.

(9) No coverage will be available under Insuring Clause 2 or 3 for loss or damage due to fire; provided that this Exclusion shall not apply to:

(i) loss of **Money** or **Securities**; or

(ii) damage to any safe or vault caused by the application of fire thereto for the purposes of **Safe Burglary**.

(10) Exclusion 12(k) of this coverage section is deleted.

(11) No coverage will be available under Insuring Clause 2, 3, 4, 5, 6, or 8 for loss due to an **Insured** knowingly having given or surrendered **Money**, **Securities** or **Property** in any exchange or purchase with a **Third Party**; provided that this Exclusion shall not apply to otherwise covered loss of **Property** under Insuring Clause 5.

(12) Exclusion 17 of this coverage section is deleted.

(13) Exclusion 19 of this coverage section is amended to read in its entirety as follows:

19. No coverage will be available under this coverage section for:

(a) loss unless sustained by an **Insured** prior to the termination of this coverage section as to such **Insured**, and **Discovered** and written notice thereof is given to the Company within ninety (90) days following such termination;

(b) loss unless sustained prior to the termination of any Insuring Clause or any particular coverage offered under any Insuring Clause, and **Discovered** and written notice thereof is given to the Company within ninety (90) days following such termination; or

(c) loss unless sustained prior to the termination of this coverage section in its entirety, and **Discovered** and written notice thereof is given to the Company within ninety (90) days following such termination;

provided that in no event will coverage be available under this coverage section for such loss if such loss is covered under any renewal or replacement of this coverage section or any Insuring Clause or any particular coverage offered under any Insuring Clause issued by the Company or by any affiliate of the Company.

(14) The second paragraph of Subsection 20 Ownership is amended to read in its entirety as follows:

Solely for the purposes of Insuring Clause 9, the Company's liability under this coverage section will apply only to **Money**, **Securities** or **Property**:

(a) owned by a **Client**, which is held by the **Organization** in any capacity or for which the **Organization** is legally liable; or

(b) held by the **Client**, for which the **Client** is legally liable.

(15) The second paragraph of Subsection 23 Changes in Exposure of this coverage section is amended to read in its entirety as follows:

If the total revenues of any such acquired organization or new **Subsidiary** exceed thirty percent (30%) of the total revenues of the **Parent Organization** (as reflected in the most recent audited consolidated financial statements of such organization and the **Parent Organization**, respectively, as of the date of such acquisition or creation), the **Parent Organization** shall give written notice of such acquisition or creation to the Company as soon as practicable, but in no event later than ninety (90) days after the date of such acquisition or creation, together with such information as the Company in its sole discretion may require and shall pay any reasonable additional premium required by the Company. If the **Parent Organization** fails to give such notice within the time specified in the preceding sentence, or fails to pay the additional premium required by the Company, coverage for such acquired organization or new **Subsidiary** shall be null and void from the date of such acquisition or creation. Coverage for such acquired organization or new **Subsidiary** shall be subject to such additional or different limitations, conditions, provisions or other terms as the Company in its sole discretion may require.

(16) Subsection 25 Limits of Liability and Retention is amended to include the following:

If any loss is covered in part under this coverage section and in part under a prior bond or policy, the applicable Retention set forth in Item 3 of the Declarations for this coverage section shall be reduced by the retention applied to such loss by the superseded insurance carrier.

(17) Subparagraph (a) of Subsection 28 Valuation and Foreign Currency of this coverage section is amended to read in its entirety as follows:

(a) the actual market value of lost, damaged or destroyed **Securities** at the closing price of such **Securities** on the business day immediately preceding the day on which a loss is **Discovered**, or the cost of replacing such **Securities**, whichever is less, plus the cost to post a Lost Instrument Bond;

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 6

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND EMPLOYEE THEFT COVERAGE INSURING CLAUSE ENDORSEMENT

In consideration of the premium charged, it is agreed that Insuring Clause (1), Employee Theft Coverage, of this coverage section is deleted and replaced with the following:

1. Employee Theft Coverage Insuring Clause 1

   The Company shall pay the **Parent Organization** for direct loss of **Money**, **Securities** or **Property** sustained by an **Insured** resulting from **Theft** or **Forgery** committed by an **Employee**, whether identified or not, acting alone or in collusion with others.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.

Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 7

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

PENSION PROTECTION ACT ENHANCEMENT ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) The definition of **Employee** as defined in Subsection 11., Definitions, of this coverage section, subparagraph (d) is deleted and replaced with the following:

(d) natural person fiduciary, trustee, administrator or other plan official, while in the regular service of an **ERISA Plan**, and any other natural person who handles **ERISA Plan** assets who is required to be bonded by an **Organization** in connection with such **ERISA Plan** by Title 1 of the Employee Retirement Income Security Act of 1974, as amended, and as amended by the Pension Protection Act of 2006.

(2) The definition of **ERISA Plan** as defined in Subsection 11., Definitions, of this coverage section, is deleted and replaced with the following:

ERISA Plan means any Employee Benefit Plan, Pension Benefit Plan, or Welfare Benefit Plan, defined and required to be bonded under Title 1 of the Employee Retirement Income Security Act of 1974, as amended, and the Pension Protection Act of 2006, which is operated solely by an **Organization** or jointly by an **Organization** and a labor organization for the benefit of **Employees** and which existed on or before the inception of this coverage section or which is created or acquired after the inception of this coverage section.

(3) Subsection 21, **ERISA Plan**, the first full paragraph is deleted and replaced with the following:

Solely with respect to loss sustained by an **ERISA Plan**, payment by the Company for covered loss shall be to the **ERISA Plan** sustaining such loss. If such payment is in excess of the amount of coverage required by the Employee Retirement Income Security Act of 1974, as amended, for said Plan(s), such excess shall be held for the use and benefit of any other named Plan(s) should such Plan(s) also discover loss recoverable hereunder.

With respect to any **ERISA Plan**:

a. if covered loss is sustained by any **ERISA Plan** which does not have any employer securities, the Limit of Liability applicable to such covered loss shall be the lesser of ten percent (10%) of the **ERISA Plan's** funds handled as of the beginning of such **ERISA Plan's** fiscal year or five hundred thousand dollars ($500,000); or

b. if covered loss is sustained by any **ERISA Plan** which does have any employer securities, the Limit of Liability applicable to such covered loss shall be the lesser of ten percent (10%) of the **ERISA Plan's** funds handled as of the beginning of such **ERISA Plan's** fiscal year or one million ($1,000,000);

provided that, in all events, (i) if the applicable Limit of Liability as set forth in Item 2 of the Declarations of this coverage section is less than the amounts set forth in paragraphs a. or b. above, then the applicable Limit of Liability shall be amended to the respective amounts set forth in paragraphs a. or b. above; or (ii) if the applicable Limit of Liability as set forth in Item 2 of the Declarations of this coverage section equals or exceeds the amounts set forth in paragraphs a. or b. above, then the applicable Limit of Liability shall be the Limit of Liability as set forth in Item 2 of the Declarations of this coverage section.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 8

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

PRIVACY AND DATA BREACH EXCLUSIONS ENDORSEMENT

In consideration of the premium charged, it is agreed that Section III, Exclusions of this coverage section, is amended as follows:

1. Exclusion 12.(b) is deleted.

2. No coverage will be available for:

   (i) loss involving the disclosure of an **Insured's** or another entity or person's confidential or personal information while in the care, custody or control of an **Insured** including, but not limited to, patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any similar type of nonpublic information;

   (ii) loss involving the use of another entity or person's confidential or personal information while in the care, custody or control of an **Insured** including, but not limited to, patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any similar type of nonpublic information; or

   (iii) fees, costs, fines, penalties or any other expenses incurred by an **Insured** which result, directly or indirectly, from the access to or disclosure of another entity or person's confidential or personal information, including but not limited to, patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any similar type of nonpublic information,

   provided, however, that the above exclusions shall not apply to loss that is otherwise covered under Insuring Clause 6, Funds Transfer Fraud Coverage.

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 9

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND DEFINITION OF EMPLOYEE ENDORSEMENT

In consideration of the premium charged, it is agreed that the term **Employee**, as defined in Subsection 11 Definitions of this coverage section, is amended to include any former natural person employee of an **Organization** while in the regular service of such **Organization** as a consultant pursuant to a written contract between such person and such **Organization**.

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 10

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND EXCLUSION 13(b)(iii) ENDORSEMENT

In consideration of the premium charged, it is agreed that clause (iii) of Exclusion 13(b) of this coverage section is amended to read in its entirety as follows:

(iii) more than ninety (90) days following the termination of such **Employee**.

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement: July 1, 2014

Company: Federal Insurance Company

Endorsement No. 11

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND ITEM 3 OF THE DECLARATIONS ENDORSEMENT

In consideration of the premium charged, it is agreed that Item 3 of the Declarations for this coverage section is amended to read in its entirety as follows:

Item 3. Retention:

(A)	Clause 1	Employee Theft	$100,000.00
(B)	Clause 2	Premises	$100,000.00
(C)	Clause 3	In Transit	$100,000.00
(D)	Clause 4	Forgery	$100,000.00
(E)	Clause 5	Computer Fraud	$100,000.00
(F)	Clause 6	Funds Transfer Fraud	$100,000.00
(G)	Clause 7	Money Order & Counterfeit Fraud	$1,000.00
(J)	Clause 8	Credit Card Fraud	$1,000.00
(I)	Clause 9	Client	$100,000.00
(J)	Clause 10	Expense	N/A

The title and any headings in this endorsement are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this policy shall remain unchanged.



Authorized Representative

ENDORSEMENT/RIDER

Coverage Section: Health Care Portfolio Crime Coverage Section (Federal)

Effective date of
this endorsement/rider: July 1, 2014

Federal Insurance Company

Endorsement/Rider No. 12

To be attached to and
form a part of Policy No. 8224-0373

Issued to: DAUGHTERS OF CHARITY HEALTH SYSTEM

AMEND CLIENT ENDORSEMENT

In consideration of the premium charged, it is agreed that the term **Client**, as defined in Subsection 11 Definitions of this coverage section, is amended to read in its entirety as follows:

> **Client** means a patient or customer of an **Organization** to whom such **Organization** provides services under written contract or for a fee.

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.



Authorized Representative

CLYDE&CO

Clyde & Co US LLP
2020 Main Street
Suite 1100
Irvine, California 92614
Telephone: (949) 852-8200
Facsimile: (949) 567-7850
www.clydeco.us

January 10, 2025

VIA ELECTRONIC MAIL

Louise Ann Fernandez, Esq.
Bartko LLP
1100 Sansome Street
San Francisco, CA 94111

Re:	**Insureds:**	**(1) Daughters of Charity of St Vincent de Paul Province of The West;**
		(2) Daughters of Charity Health System
	Policy:	**Health Care Portfolio**
	Policy Nos.:	**(1) 8209-2943;**
		(2) 8224-0373
	Policy Period:	**July 1, 2014 to July 1, 2015**
	Policy Limits:	**(1) $10 million Limit of Liability for each Fiduciary Claim, subject to a $10,000 retention per Claim;**
		(2) $10 million Limit of Liability for each Fiduciary Claim, subject to a $1 million retention per Claim
	Clyde File No.:	**01115-10710412**
	Matter:	**ERISA litigation filed by Rachel Oden**

Dear Ms. Fernandez:

Our firm is coverage counsel for Federal Insurance Company ("Federal") which issued the above-captioned Health Care Portfolio Policies as they may relate to the putative class action lawsuit brought by Rachel Oden against the Verity Health System Benefits Administration Committee (the "Committee") and three alleged fiduciaries of a retirement plan allegedly subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* (the "Oden Lawsuit").

The purpose of this letter is to provide Federal's coverage position regarding this matter. We ask that you provide a copy of this correspondence to all appropriate corporate officials.

LIMITS OF LIABILITY AND APPLICABLE DEDUCTIBLES

Federal issued Health Care Portfolio Policy No. 8209-2943 to Daughters of Charity of St. Vincent de Paul Province of the West ("DOCPW"), with a policy period of July 1, 2014 to July 1, 2015 (the

CLYDE&CO

"DOCPW Policy"). The DOCPW Policy contains both Fiduciary Liability Coverage and Voluntary Settlement Program Coverage. The Fiduciary Liability Coverage has a $10 million limit of liability for each **Fiduciary Claim**, subject to a $10,000 retention for each **Fiduciary Claim** under Insuring Clause 1.

Federal also issued Health Care Portfolio Policy No. 8224-0373 to Daughters of Charity Health System ("DOCHS"), with a policy period of July 1, 2014 to July 1, 2015 (the "DOCHS Policy"). The DOCHS Policy consists of both Fiduciary Liability Coverage and Crime Coverage. The Fiduciary Liability Coverage ("Fiduciary Section") has a $10 million limit of liability for each **Fiduciary Claim**, subject to a $50,000 retention for a **Non-Class Action** and a $1 million retention for a **Class Action** under Insuring Clause 1. Because the Complaint is brought as a Class Action, the $1 million retention applies.

CLAIM SUMMARY

On August 30, 2024, Rachel Oden ("Plaintiff"), on behalf of herself and a class of all others similarly situated, filed a class action complaint (the "Complaint") in the U.S. District Court, Central District of California, against the Committee, Chris Carson, Peter Chadwick, and Steven C. Sharrer (Carson, Chadwick, and Sharrer are collectively referred to in the Complaint as the "Individual Defendants," and together with the Committee, the "Defendants"). The Committee, Individual Defendants, and John and Jane Does 1-10 are collectively referred to in the Complaint as the Committee Defendants. John and Jane Does 11-20 are the unknown members of the Board of Directors of Verity Health System ("Verity") between December 14, 2015 and October 15, 2019 and are collectively referred to in the Complaint as the Director Defendants.

Plaintiff alleges that she is the daughter of the late Loraine Oden, a former employee at St. Francis Medical Center ("St. Francis") and a participant in the Daughters of Charity Health System Retirement Plan, later renamed Verity Health System Retirement Plan A (the "Plan" or "Plan A"). Plaintiff maintains that the Committee was designated as the Plan Administrator and a fiduciary of Plan A within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A). Plaintiff alleges that the Individual Defendants were members of the Committee and fiduciaries of Plan A within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A).

Plaintiff brings this ERISA action on behalf of a class of participants in and beneficiaries of Plan A and Verity Health System Retirement Plan B ("Plan B") (the "Plan" and Plan B" are collectively referred to as the "Plans), alleging that the Committee and its members breached their fiduciary duties by failing to take steps to protect participants in the Plans and improperly operating the Plans. The benefits of the Plans were allegedly reduced as a result of this underfunding and lack of

CLYDE&CO

payment of insurance premiums to the Pension Benefit Guaranty Corporation ("PBGC") for the amount of time it would have ensured fully-insured benefits by the PBGC after Verity declared bankruptcy.

Plaintiff claims that DOCHS and its Benefits Administration Committee wrongfully operated Plan A as if it were a "church plan" exempt from Title I and Title IV of ERISA whereas Plan A was in fact not a church plan under ERISA. Plaintiff asserts that DOCHS described the benefits provided by Plan A to employees in various communications, but never established Plan A pursuant to a written instrument within the meaning of ERISA § 402, 29 U.S.C. § 1102. Plaintiff further asserts that DOCHS failed to set a funding policy that would adequately fund the anticipated obligations of Plan A every year since at least approximately 2010 and failed to make contributions to Plan A in satisfaction of the minimum funding requirements of ERISA § 302, 29 U.S.C. § 1082 since at least 2002. Additionally, Plaintiff asserts that Plan A was already underfunded by millions of dollars in 2012 when DOCHS adopted a funding policy that amortized over ten years the unfunded liability as of January 1, 2012 and required DOCHS to make payments accordingly. Plaintiff claims that, in setting a funding policy that was so profoundly inadequate, DOCHS and other fiduciaries of Plan A breached their duties under ERISA § 404(a)(1)(A) and (B), 29 U.S.C. § 1104(a)(1)(A) (B), to administer the plan prudently and in the best interests of Plan A participants and beneficiaries.

According to Plaintiff, Plan A obtained PGBC coverage on December 14, 2015, when it was amended and restated to make it expressly subject to the requirements of ERISA, based on the Verity Health System Retirement Plan (Amended and Restated Effective December 14, 2015) ("the 2015 Plan Document"), and only began paying PBGC insurance premiums from that point forward. Because Plan A had only been covered by PBGC insurance for two full years as of the date Verity declared bankruptcy, the PBGC only guaranteed 40% of the pension benefits of Plaintiff and the Class. Plaintiff asserts that PBGC explicitly informed Plaintiff that her benefit was being reduced because Plan A had been underfunded and underinsured.

Plaintiff alleges that, had DOCHS not improperly claimed church plan status, Plan A would have had to meet the funding requirements of ERISA and the plan sponsor/employer would have been paid premiums to the PBGC. Plaintiff further asserts that, had the Committee timely filed suit against former fiduciaries of Plan A who had improperly operated it as a church plan, and/or the prior employer/plan sponsor, they could have remedied Plan A's underfunding. As a result of the Committee's failure to properly take such corrective action as part of its fiduciary duties, Plaintiff and other members of the Class have been harmed by having their benefits reduced as a result of Plan A's underfunding and lack of payment of insurance premiums to the PBGC for the amount of time it would have ensured fully-insured benefits by the PBGC after Verity declared bankruptcy.

CLYDE&CO

Plaintiff asserts that the Director Defendants had a duty to monitor the trustees' conduct and to take appropriate action if those fiduciaries were not adequately protecting the interests of Plan A participants, but took no steps to protect Plan A participants or otherwise remedy the violations. Plaintiff also asserts that, by failing to properly monitor and/or take appropriate action against the Committee Defendants, the Director Defendants breached their fiduciary duties under ERISA § 404(a)(1)(A) & (B), 29 U.S.C. § 1104(a)(1)(A) & (B).

The Complaint contains the following three causes of action: (i) Breach of Fiduciary Duty in Violation of ERISA § 404(a)(1)(A) and (B), 29 U.S.C. § 1104(a)(1), against the Committee Defendants pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); (ii) Breach of Duty to Monitor pursuant to ERISA § 404(a)(1)(A) & (B), 29 U.S.C. § 1104(a)(1)(A) & (B) against the Director Defendants; and (iii) Co-Fiduciary Liability Pursuant to ERISA § 405, 29 U.S.C. § 1105 against all Defendants.

Plaintiff seeks the following relief: (1) declare that Defendants have each breached their fiduciary duties under ERISA or California state law); (2) award the equitable remedy of surcharge against Defendants to make Plaintiff and other members of the Class whole; (3) require Defendants to pay attorneys' fees and costs pursuant to ERISA § 502(g), 29 U.S.C. § 1132(g); and (4) award pre-judgment interest and post-judgment interest.

COVERAGE EVALUATION

As discussed below, no coverage is afforded for the Oden Lawsuit under the DOCHS Policy and the DOCPW Policy (collectively, the "Policies") because the Oden Lawsuit does not satisfy the requirements for coverage under Insuring Clause 1 of the Fiduciary Section of the Policies. Specifically, coverage thereunder is limited to **Wrongful Acts** that occurred before or during the July 1, 2014 to July 1, 2015 policy period and all of the alleged **Wrongful Acts** for which Plaintiff alleges that Defendants are liable occurred after the Policies expired. Additionally, coverage under the DOCHS Policy is precluded by operation of Section 15(b) of the Fiduciary Section [Acquisition by Another Organization/Financial Impairment] of the Policies, which limits coverage to **Wrongful Acts** performed before Integrity Healthcare, LLC's ("Integrity") acquisition of the right to control, manage, or appoint directors and officers of DOCHS. Again, all of the alleged **Wrongful Acts** occurred after the acquisition. Further, no coverage is afforded under the DOCPW Policy as none of the Defendants qualify as **Insureds** thereunder. Finally, were coverage otherwise available, indemnity coverage under the Policies would be limited by operation of the Benefits Due Exclusion.

CLYDE&CO

I. **No Coverage Is Afforded For The Oden Lawsuit Under The Policies As Defendants' Alleged Liability Arises Exclusively From Wrongdoing After Expiration Of The Policies.**

Insuring Clause 1 of the Fiduciary Section of the Policies (the "Fiduciary Insuring Clause") provides, in pertinent part, as follows:

> The Company shall pay, on behalf of the **Insureds**, **Loss** for which the **Insureds** become legally obligated to pay on account of any **Fiduciary Claim** first made against the **Insureds** during the **Policy Period**, or, if exercised, during the Extended Reporting Period, for a **Wrongful Act** committed, attempted, or allegedly committed or attempted before or during the **Policy Period** by such **Insureds**, or by any person for whose **Wrongful Acts** the **Insureds** are legally responsible, but only if such **Fiduciary Claim** is reported to the Company in writing in the manner and within the time provided in Subsection 10 of this coverage section.

As quoted above, the Fiduciary Insuring Clause provides coverage solely for a **Wrongful Act** allegedly committed by an **Insured** before or during the **Policy Period**. Any **Wrongful Act** allegedly committed after July 1, 2015, the expiration date of the Policies, is not be covered under the Policies. As discussed below, each of the three Counts in the Oden Lawsuit are premised exclusively on wrongdoing after formation of the Committee, which did not exist while the Policies were in effect.

Plaintiff alleges that this action is brought on behalf of herself and other Class members who are participants in and beneficiaries of the Plans, alleging that the Committee and its members "breached their fiduciary duties by failing to take steps to protect Plan participants and improperly operating the Plan." Plaintiff also alleges that "[a]s the [Committee] was the Plan Administrator and a named fiduciary of the Plan in accordance with the terms of the written instrument of the Plan, and because the [Committee] and its members had discretionary authority or responsibility for the administration of the Plan," the Committee, Carson, Chadwick, and Sharrer were the fiduciaries of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C § 1002(21)(A).

Count I is asserted against the Committee Defendants, including the Committee, the Individual Defendants, and John and Jane Does 1-10. Plaintiff claims the Committee had the power to institute claims against DOCHS and prior Plan fiduciaries based on power granted by the Plan's provision. Plaintiff further maintains that the Committee Defendants had the power to institute claims against Verity for Verity's failure to set a prudent funding policy and to institute claims for breach of fiduciary duty under California state law against Plan fiduciaries, DOCHS, and Verity, which had caused the persistent and severe underfunding of the Plan and adopted inadequate measures to remedy its severe underfunding. Additionally, Plaintiff claims that the Committee

Defendants failed to institute a lawsuit for a breach of fiduciary duties or other violations including failure to properly fund the plan or pay PBGC premiums against DOCHS, Verity, or the pre-Verity fiduciaries, thereby failing to manage the assets of the Plan with care, skill, diligence, and prudence in violation of ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B). Plaintiff also alleges that the Committee Defendants' failure to institute such lawsuit against former fiduciaries were motivated at least in part by unwillingness on the part of members of the Committee to sue themselves, other executives and employees of Verity, or Verity. It is alleged that, had the Committee Defendants brought such an action, they would have included Verity (as successor of DOCHS) and former or current members of the Committee appointed by DOCHS. Therefore, the Committee Defendants allegedly placed the interests of themselves, of other executives and employees of Verity, and of Verity ahead of the interests of participants in the Plans in violation of ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A).

As reflected above, all of the alleged breaches of duty in Count I concern acts and responsibilities connected to the Committee. Accordingly, the potential liability under Count I could not have arisen until the Committee was appointed. The Committee was appointed pursuant to the 2015 Plan Document, which became effective on December 14, 2015, after the Policy Period. Therefore, any liability arising from Count I would necessary arise from a **Wrongful Act** that occurred after the Policies expired and, thus, no coverage for Count I is afforded under the Policies.

In Count II, Plaintiff alleges that, "[p]ursuant to Section 3.1 of the 2015 Plan Document, the Board of Directors of [Verity] appointed the [Committee] and had the power to remove them." Plaintiff also alleges that "[p]ursuant to that authority, the Director Defendants had a duty to monitor the Trustees' conduct and to take appropriate action" but failed to "properly monitor and/or take appropriate action against the [Committee Defendants]," thereby breaching their fiduciary duties under ERISA § 404(a)(1)(A) & (B), 29 U.S.C. § 1104(a)(1)(A) & (B). As the duties at issue in Count II derive from the 2015 Plan Document, which became effective on December 14, 2015, the alleged breach of duties would have occurred no earlier than December 14, 2015, which is after the Policies expired. Accordingly, no coverage is afforded under the Policies for Count II.

Finally, in Count III, Plaintiff alleges that, had Defendants properly exercised their fiduciary duties, Defendants would have discovered that operating the Plan as a church plan was improper and the prior fiduciaries had breached their fiduciary duties and the prior fiduciaries and DOCHS engaged in prohibited transactions in violation of ERISA. Plaintiff further alleges the failure of the Committee Defendants to bring suit against DOCHS and the pre-Verity fiduciaries breached their duties to comply with ERISA § 404(a)(1) in the administration of their specific responsibilities as fiduciaries and the failure of the Director Defendants to monitor the Committee and, as necessary, remove its members enabled the Committee Defendants to violate ERISA by violating their fiduciary duties to bring suit against the former fiduciaries of the Plan. Likewise, the Committee Defendants' alleged

breach of duties derives from their failure to bring a lawsuit against DOCHS, Verity, the previous fiduciaries of the Plan, preceding the Committee, and the Director Defendants' alleged breach of duties derives from their failure to monitor the Committee. Accordingly, the potential liability under Count III could not have arisen at least until the Committee was appointed, which occurred after expiration of the Policies. Therefore, no coverage is afforded under the Policies for Count III.

In sum, Plaintiff in the Oden Lawsuit alleges **Wrongful Acts** that occurred exclusively after the policy period of the Policies, and thus, the requirements for coverage under the Fiduciary Insuring Clause are not satisfied. Accordingly, no coverage is afforded for the Oden Lawsuit under the Policies.

II. No Coverage Is Afforded For The Oden Lawsuit Under The DOCHS Policy By Operation Of Section 15(b) [Acquisition By Another Organization].

As amended by Endorsement No. 7 [Amend Subsections 8 And 15 To Remove Financial Impairment Provisions Endorsement], Section 15(b) of the Fiduciary Section [Acquisition by Another Organization/Financial Impairment] of the DOCHS Policy states, in pertinent part, that "If:"

> (a) the **Parent Organization** merges into or consolidates with another organization and the **Parent Organization** is not the surviving entity;
>
> (b) another organization or person or group of organizations and/or persons acting in concert acquires securities or voting rights which result in ownership or voting control by the other organization(s) or person(s) of more than fifty percent (50%) of the outstanding securities or voting rights representing the present right to vote for the election of or to appoint directors, trustees or **Managers** of the **Parent Organization**, or acquires the right to control or direct the managerial decisions of the **Parent Organization**; []
>
> then coverage under this coverage section shall continue until termination of this coverage section, but only with respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by Insureds before such merger, consolidation, [or] acquisition. Upon the occurrence of any event described in (a), [or] (b) of this Subsection 15, the entire premium for this coverage section shall be deemed fully earned.

We understand that, in 2015, DOCHS marketed their health system for sale. In July 2015, the DOCHS Board of Directors selected BlueMountain Capital Management LLC ("BlueMountain"), a

CLYDE&CO

private investment firm, to recapitalize its operations and transition leadership of the health system to the new "Verity." On July 14, 2015, DOCHS' Board of Directors passed a resolution to authorize the execution of a System Restructuring and Support Agreement ("System Agreement") between DOCHS, Daughters of Charity Ministry Services Corporation ("DOCMS," the sole corporate member of DOCHS), BlueMountain, and Integrity (an entity owned by BlueMountain that was developed to oversee DOCHS and DOCHS' affiliates), and recommended the approval of the transaction to DOCMS' Board of Directors, which passed a resolution to authorize the execution of the System Agreement (the "BlueMountain Transaction").

We understand that, in connection with the BlueMountain Transaction, BlueMountain agreed to make a capital infusion of $100 million to the hospital system, arrange loans for another $160 million to the health system, and manage operations of the health system, with an option to buy the health system at a future time. The System Agreement provided, among other things, that DOCHS' name would be changed to Verity after the closing of the BlueMountain Transaction, and Integrity would be formed to carry out the management services under a new management agreement.

The System Agreement was amended in September 2015, whereby DOCHS agreed to enter into a number of supplemental agreements, including, among others, a Health System Management Agreement ("Management Agreement"). The major provisions of the Management Agreement included, *inter alia*, the following:

- [DOCHS] designates and appoints Integrity as its sole exclusive agent to provide and assume responsibility for the management, administrative, and support services of [DOCHS] and [DOCHS]' Affiliates;
- Subject to budgetary limitations and personnel allocations, Integrity shall provide management services for the continuing operation of [DOCHS] by, among other things, supervising, overseeing, and directing (including, but not limited to, the right to hire, discipline, suspend, lay off and/or terminate) [DOCHS]' personnel;
- Integrity shall employ and provide a Chief Executive Officer, Chief Operating Officer, Director of Medical and Clinical Affairs, and a Chief Financial Officer for [DOCHS]; and
- Integrity has the exclusive right to provide such services as [DOCHS] determines to be necessary or appropriate for the management, support, and administration of [DOCHS].

DOCHS requested the California Attorney General's consent to enter into the System Agreement and the BlueMountain Transaction. On December 3, 2015, the California Attorney General approved the BlueMoutain Transaction, subject to certain conditions.
By operation of Section 15(b), no coverage is afforded for **Claims** for **Wrongful Acts** allegedly committed by **Insureds** after the acquisition by Integrity. As discussed in the preceding section, the wrongdoing that is the basis for Defendants' alleged liability occurred no earlier than December 14,

2015, when the Committee was formed. The acquisition, however, occurred on July 14, 2015. As all of the alleged wrongdoing occurred after the acquisition, coverage for the Oden Lawsuit is precluded by operation of Section 15(b).

III. **No Coverage Is Afforded For The Oden Lawsuit Under The DOCPW Policy As Defendants Are Not Insureds Thereunder.**

Coverage under the Policies is limited to an **Insured**, which is defined in the Policies to mean the **Organization**, any **Plan** and any **Insured Person**.

Insured Person is defined in the Policies to include the following:

(a) any past, present or future **Executive** or **Employee**; and

(b) any past, present or future natural person trustee or fiduciary of a multi-employer plan, if such person in such capacity is added as an **Insured Person** by specific written endorsement to this coverage section.

Executive is defined to include "any natural person who was, now is or shall become … a duly elected or appointed director, officer, trustee, **Manager,** duly constituted committee member, or in-house general counsel of any **Plan** or any **Organization** chartered in the United States of America[.]" **Employee** is defined to mean "any natural person whose labor or service is engaged by and directed by the **Organization** or any **Plan**, including any part-time and temporary employee or any volunteer."

Organization is defined in the Policies to mean "the **Parent Organization** and any **Subsidiary**, including any such organization in its capacity as a debtor in possession under the United States bankruptcy law or in an equivalent status under the law of any other country. **Organization** shall also include any **Affiliate** added as an affiliate by specific written endorsement to the General Terms and Conditions Section of this policy." **Affiliate** is defined to mean "any entity added as an affiliate by specific written endorsement to these General Terms and Conditions." There is no endorsement adding any entity as an **Affiliate**. **Parent Organization** is defined as DOCPW in the Declarations.

Subsidiary is defined, in pertinent part, as follows:

> **Subsidiary** means any organization while more than fifty percent (50%) of the outstanding securities or rights representing the present right to vote for election of or to appoint directors or trustees of such organization are owned, directly or indirectly, in any combination, by one or more **Organizations**; provided that **Subsidiary** shall not include any **Affiliate**.

CLYDE&CO

According to the Complaint, Defendants are associated with/employed by Verity and/or St. Vincent Medical Center ("St. Vincent"). These entities are separate and distinct from DOCPW. According to the Declaration Of Richard G. Adcock In Support Of Emergency First-Day Motions, Doc. No. 8, filed on August 31, 2018 in the Bankruptcy Action, Verity was originally owned and operated by DOCPW. In March 1995, DOCPW merged with Catholic Healthcare West. In June 2021, DOCHS was formed. In October 2001, DOCPW withdrew from DOCHS. In 2002, DOCHS commenced operations and was the sole corporate member of O'Connor Hospital, St. Louise Regional Hospital, Seton Medical Center, Seton Coastside, St. Francis, and St. Vincent, which at that time were California nonprofit religious corporations. Accordingly, neither Verity nor St. Vincent constitute **Subsidiaries** of DOCPW. Therefore, Verity and St. Vincent do not qualify as **Organizations** under the DOCPW Policy.

Plan is defined to include "any **Sponsored Plan**," which is defined to include "any Employee Benefit Plan, Pension Benefit Plan or Welfare Benefit Plan, as each are defined in **ERISA**, which is operated solely by the **Organization** or jointly by the **Organization** and a labor organization solely for the benefit of the **Employees** or **Executives** of the **Organization** located anywhere in the world and which existed on or before the inception date set forth in Item 2 of the Declarations of the General Terms and Conditions or which is created or acquired after such inception date." As the Plan is operated by Verity, which does not constitute an **Organization** under the DOCPW Policy, it would not constitute a **Sponsored Plan** or **Plan** under the DOCPW Policy.

The Individual Defendants (and the doe defendants) would not constitute **Employees** or **Executives**, as they have no connection with any **Organization** or any **Plan** under the DOCPW Policy. Therefore, they would not constitute **Insured Persons**.

For the foregoing reasons, no coverage is afforded under the DOCPW Policy, as the Defendants named in the Oden Lawsuit are not the **Insureds** and thus are not covered thereunder.

IV. **Other Coverage Limitations.**

While the above issues are dispositive to coverage, we discuss below certain other terms, conditions, and exclusions in the Policies.

A. **Insureds Under The DOCHS Policy.**

As noted above, the Policies provide coverage to the **Insured**, which is defined to mean the **Organization**, any **Plan** and any **Insured Person**. The Committee is not a natural person or legal entity, and thus would not constitute an **Organization**, **Plan**, or **Insured Person** under either of

the Policies. As such, the Committee would not constitute an **Insured** under the Policies. Federal reserves all rights as to whether the Individual Defendants qualify as **Insureds** under the DOCHS Policy.

B. **The Benefits Due Exclusion.**

Section 5(b) [Benefits Due Exclusion] of the Fiduciary Section, as amended by Endorsement 14 [Amend Benefits Due Exclusion Endorsement] of the DOCHS Policy and Endorsement 16 [Amend Benefits Due Exclusion Endorsement] of the DOCPW Policy, provides that "[t]he Company shall not be liable for **Loss**, other than **Defense Costs**:"

> [W]hich constitutes (i) benefits due or to become due under any **Plan**, or (ii) benefits which would be due under any **Plan** if such Plan complied with all applicable law, including but not limited to **Loss** resulting from the payment of plaintiff attorneys' fees based upon a percentage of such benefits or payable from a common fund established to pay such benefits, except to the extent that:
>
> (A) an **Insured** is a natural person and the benefits are payable by such **Insured** as a personal obligation, and recovery for the benefits is based upon a covered **Wrongful Act**; or
>
> (B) a **Fiduciary Claim** made against an **Insured** alleges a loss to the **Plan** and/or to the accounts of such **Plan**'s participants by reason of a change in the value of the investments held by such **Plan**, regardless of whether the amounts sought or recovered by the plaintiffs in such **Fiduciary Claim** are characterized by plaintiffs as "benefits" or held by a court as "benefits"; or

Plaintiff in the Oden Lawsuit alleges the benefits that she and the Class members received were reduced because the Plan was underfunded and underinsured, and the benefits of Plaintiff and other members of the Class would have been paid in full, had the Plan complied with ERISA's pension funding requirements. The equitable remedy of surcharge is sought by Plaintiff to obtain benefits due under the Plan. Accordingly, were coverage otherwise afforded, any such coverage would be limited by operation of the Benefits Due Exclusion. All of Federal's rights in connection with this exclusion should be considered fully reserved.

C. **Date Of Claim.**

It is a requirement for coverage under the Fiduciary Insuring Clause that "any **Fiduciary Claim** [be] first made against the **Insureds** during the **Policy Period**, or, if exercised, during the Extended Reporting Period…"

CLYDE&CO

Subsection 9 [Limit of Liability and Retention] (f) of the Fiduciary Section of the Policies provides that "[a]ll **Related Claims** shall be treated as a single **Claim** first made on the date the earliest of such **Related Claims** was first made, or on the date the earliest of such **Related Claims** is treated as having been made in accordance with Subsection 10(b) of this coverage section, regardless of whether such date is before or during the **Policy Period**." **Related Claims** is defined to mean all **Claims** for **Wrongful Acts** based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events.

Federal reserves all rights as to whether the Oden Lawsuit is a **Fiduciary Claim** deemed first made during the period of the Policies.

V. **Conclusion.**

For the reasons set forth above, no coverage is afforded under the Policies for the Oden Lawsuit. To the extent that you disagree with Federal's conclusion, please provide your factual or legal basis to our office for Federal's consideration.

You may have the matter reviewed by the California Department of Insurance, which you may contact by writing to the following agency: California Department of Insurance, Claims Services Bureau, 300 South Spring Street, Los Angeles, California 90013. You may also call the Consumer Communications Bureau at the following telephone numbers: 1 (800) 927-4357 or 1 (213) 897-8921.

Please be advised that Federal does not waive any of its rights as to all terms, conditions and defenses available under the Policies and the law, all of which are expressly reserved.

Very Truly Yours,

Ralph Guirgis
Clyde & Co US LLP

cc: Josiah R. Jenkins

RAG:SRS

Execution Copy

HEALTH SYSTEM MANAGEMENT AGREEMENT

THIS HEALTH SYSTEM MANAGEMENT AGREEMENT (this "Agreement") is entered into on December 14, 2015 (the "Effective Date") by and between Integrity Healthcare, LLC, a Delaware limited liability company ("Manager"), and Verity Health System of California, Inc. ("Health System"). Manager and the Health System are sometimes collectively referred to herein as the "Parties" and individually referred to herein as a "Party."

WHEREAS, Health System engages in the business of delivering healthcare services to the public through the hospitals identified in Attachment I hereto (the "Hospitals") and its Affiliates (defined below) in furtherance of the mission of serving the sick and the poor by providing comprehensive healthcare services in and through the Affiliate's locations and operations;

WHEREAS, in the interest of avoiding a possible closure of the Hospitals and subsequent liquidation which more than likely would result in (i) Health System's failure to repay certain outstanding liabilities, including in respect of certain tax-exempt bonds issued by the California Statewide Community Development Authority (the "Revenue Bonds"), (ii) the loss of employment for the individuals who work for and with the Health System and (iii) the elimination of a hospital and emergency department in the applicable communities, among other results, Health System wishes to retain a qualified administrative manager for the purpose of providing certain management services to the Health System, and the businesses and operations of the Health System and for providing a Chief Executive Officer and certain other executive officers for the Health System;

WHEREAS, Manager acknowledges that its management of the Health System will be in a manner consistent with the charitable purposes (as set forth in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended) of the Health System and its tax-exempt Affiliates and the requirements of this Agreement;

WHEREAS, Health System desires to retain Manager to manage the Health System, and provide advice, counsel, and expertise to the Health System and to its Affiliates, and Manager desires to provide such services, on the terms set forth herein, and it is the Parties intent that the Agreement shall comply with all applicable legal requirements; and

NOW, THEREFORE, in consideration of the foregoing premises and the mutual representations, warranties, covenants, agreements and conditions hereinafter set forth, and intending to be legally bound hereby, each Party hereby agrees as follows:

ARTICLE I
DUTIES OF MANAGER AND HEALTH SYSTEM

1.1. Exclusive Appointment; Standard of Care.

1.1.1 Subject at all times to the ultimate supervision and authority of its Board of Directors, the Health System does hereby exclusively designate and appoint Manager as its sole and exclusive agent to provide and assume responsibility for the management, administrative and support services required under this Agreement, and Manager does hereby

accept such appointment and agrees to provide such administrative, support, and management services in accordance with the terms of this Agreement. The Parties acknowledge that the scope of both Manager's authority and duties to manage, administer, and support the Health System are limited to the authority and duties set forth in this Agreement, and as may otherwise may be limited by law.

1.1.2 Manager agrees with Health System that (a) it will execute its duties under this Agreement in a manner that exclusively furthers the charitable purposes of the Health System and its tax-exempt Affiliates as defined under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and as required under California law, and in a manner consistent with the terms and conditions of its agreements with the Health System, and that in connection with the Manager's execution of its duties under this Agreement, in the event of a conflict between business considerations and these charitable purposes, that the charitable purposes as articulated and determined by the Board of Directors of the Health System will control (the "Manager's Standard of Care"); and (b) Manager shall be acting as the agent of Health System in connection with the performance of its duties under this Agreement. Manager's Standard of Care and Manager's duties as agent to Health System are further subject to, and limited by, the terms and conditions of this Agreement and the Operating Limitations, and as may otherwise be limited by law. As Manager assists the Health System to achieve its business plan and goals, the Health System shall direct each of the Health System's Affiliates to cooperate with Manager to further the purpose and intent of this Agreement. Health System shall ensure that Manager shall be invited to attend all meetings of the Board of Directors or other governing body of each Health System's Affiliate, with the understanding and agreement that Manager shall be excluded from any executive sessions of any Board of Directors, or other governing body regarding confidential matters.

1.1.3 The Parties acknowledge that Manager's personnel and affiliates have significant experience in the business of providing management and operational services to acute care hospitals, as well as post-acute and other health care related facilities and businesses. In addition to direct management, Manager and its affiliates may at times in the future provide portfolio management services to BlueMountain Capital Management, LLC and its affiliates (hereunder referred to as "BlueMountain") with respect to health care related investments made by BlueMountain. In connection with these activities Manager, and its affiliates, including BlueMountain, have made and will continue to make, substantial investments in personnel, IT systems, risk management and other intellectual property assets and processes, all of which will be utilized by Manager in the furtherance of its obligations under this Agreement. Accordingly, Manager shall not be restricted from utilizing such assets, including Manager Employees (as defined in Section 1.4 below) in the furtherance of its obligations to the Health System under this Agreement as well as in the ordinary course of Manager's business with respect to health care facilities and related investments that are not part of the Health System. For the avoidance of doubt, System Employees (as defined in Section 1.4 below) shall not be utilized by Manager for any other purpose apart from the furtherance of its obligations to the Health System under this Agreement.

1.2. Applicable Laws. At all times during the Term (as defined below) of this Agreement, Manager shall not take or fail to take any action on behalf of the Health System in material violation of applicable Laws, including: (a) federal laws and regulations relating to the

participation by the Hospitals in the Medicare program or any other federal Health System benefit program; (b) state laws and regulations applicable to participation by the Hospitals in any state Medicaid program or any other state Health System benefit program; (c) state laws and regulations applicable to Manager; (d) applicable standards and requirements of accreditation organizations; (e) all other applicable federal, state and local laws and regulations, including those relating to the maintenance of exemptions from income and ad valorem taxes and the exclusion of interest on Bonds from gross income for tax purposes (except with respect to any Affiliate that is converted to a for-profit entity following the sale of assets of the Health System pursuant to the exercise of the purchase option(s) contemplated under those certain purchase option agreements entered into by and among the Health System's Affiliates and certain affiliate(s) of BlueMountain as of even date with the Effective Date (the "Option Agreements"); and (f) all other requirements relating to the provision of Management Services or payment for such services, including laws relating to confidentiality of patient-related information, and laws governing billing and collecting payments from payors and arrangements between providers and sources of referrals of patients, medical services or supplies. For purposes hereof, "Laws" means all federal, state, local, municipal, foreign, international, multinational or other statutes or laws (including common law), ordinances, rules, treaties, codes or regulations and all decrees, injunctions, judgments, orders, rulings, assessments or writs of any applicable Governmental Authority, and "Governmental Authority" means any federal, state or local or any foreign government, legislature, governmental entity, regulatory, administrative authority, agency or commission or any court, tribunal, or judicial or arbitral body.

1.3. System Employees. Pursuant to this Agreement, Manager shall act in a professional, competent and efficient manner and shall assist the Health System and its Affiliates in their efforts through its Affiliates to provide a quality of service consistent with and comparable to other licensed and accredited acute care hospitals in and around Los Angeles, Santa Clara and San Mateo Counties, California. In connection therewith, and subject to budgetary limitations and personnel allocations described below, Manager shall provide management services for the continuing operation of the Health System by, among other things, supervising, overseeing, and directing (including but not limited to the right to hire, discipline, suspend, lay off and/or terminate) Health System personnel, including Health System officers, employed by Health System and required in support of the Health System (the "Employees"). Manager shall employ and provide a Chief Executive Officer, Chief Operating Officer, Director of Medical and Clinical Affairs, and a Chief Financial Officer (collectively referred to as "Manager Executives") for the Health System. Manager may also employ additional personnel with respect to financial reporting, risk management and systems integration and other administrative functions (together with Manager Executives hereunder referred to as "Manager Employees"), some of whom may be employees of Manager and some of whom may be employees of affiliates of Manager, including but not limited to employees of BlueMountain, to further assist Manager in the performance of its obligations under this Agreement. Absent an agreement of Manager and the Health System to the contrary, all other members of executive management and personnel shall be and remain employees of the Health System, the Hospitals, its Affiliates or their respective subsidiary foundations ("System Employees"). Manager shall be restricted from utilizing or directing System Employees for any other purpose apart from the furtherance of its obligations to the Health System under this Agreement. The Chief Operating Officer, Director of Medical and Clinical Affairs, and Chief Financial Officer of the Health Systems and the Hospitals' officers (including the CEOs of the Hospitals, the President and

Chief Medical Officer of Verity Medical Foundation (f/k/a DCHS Medical Foundation), and other executives and officers of the Health System's Affiliates and Caritas Business Services) will report to the Chief Executive Officer of the Health System, and to the respective Board of Directors of his or her employer.

1.4. Management Services. Subject to the provisions of this Agreement and the direction and oversight of the Health System's Board of Directors, at all times during the Term of this Agreement, Manager shall have the exclusive right to provide such services as Health System determines to be necessary or appropriate for the management, support, and administration of the Health System (collectively, the "Management Services"). The Management Services will include oversight, supervision, direction, implementation or performance of any or all of the following, on behalf of the Health System and, related to the Health System's Affiliates for consultation, advice, recommendations, and performance improvement plans for the Health System, as appropriate, with respect to the following:

(a) hiring, orientation, training, evaluation, and termination, of all of the Employees and contractors of Health System or Manager in support of the Management Services;

(b) on behalf of Health System, employing or engaging a qualified executive to serve as the Chief Executive Officer of the Health System;

(c) leasing and maintenance of the real property and the repair or construction of equipment as required by the terms of this Agreement;

(d) billing for medical care, products, and services provided by the Health System and its Affiliates, to the general public rendered before (as necessary) or after the Effective Date of this Agreement, collection of revenue for such care, products, and services (subject to any limitations set forth in Article III below) and settlement or compromise of any such amounts;

(e) financial management and accounting services for the Health System;

(f) preparation of policies, procedures, and other materials and all communications and public relations regarding the Health System;

(g) credentialing or certification activities on behalf of Health System physicians and other licensed medical care professionals;

(h) contract negotiations with payors on behalf of Health System;

(i) preparation of periodic reports pertaining to the Health System;

(j) preparation of quarterly and annual operating and capital budgets for the Health System, to be reviewed and approved by the Board of Directors of Health System;

(k) development planning and activities of the Health System, including pursuit of joint partnerships, clinical affiliations, co-management arrangements, and the like;

(l) provision of all patient care initiatives as required under the regulations and standards for the Health System;

(m) timely payment of all rents, insurance, taxes, operating costs and all other costs and expenses relating to operation of the Health System, before delinquency or penalty, including payments due and owing by Health System relating to the Revenue Bonds;

(n) timely payment and administration of all Retirement Plans, the Multiemployer Plans and health and welfare plans;

(o) recommendations with respect to pension structure, asset monetization or other activities designed to improve the financial well-being of the Health System; and

(p) establishing credit in Manager's own name or in the name of the Health System, and purchasing in its own name or in the name of the Health System or the Health System's Affiliates all supplies and other items necessary for the efficient operation of the Management Services.

Notwithstanding the above, to the extent Management Services relate to Hospital deficiencies arising prior to the Effective Date, Manager shall use commercially reasonable efforts to implement for the Health System, and develop for the Health System's Affiliates, appropriate corrective action plans, as necessary, but shall not be held responsible for said deficiencies, if any.

The scope and nature of the Management Services may be modified and/or expanded from time to time as set forth in a business plan approved by the Board of Directors of the Health System. However, in no event will Health System seek to diminish or duplicate the Management Services or responsibilities of Manager hereunder.

1.5. Management Initiatives and Improvements. Subject to the provisions of this Agreement, at all times during the Term of this Agreement, Manager shall use commercially reasonable efforts to improve upon the overall performance of Health System as Manager and Health System together determine may be necessary or appropriate based on their consideration of the mission of Health System and the scope of the Management Services; such commercially reasonable improvement efforts may include the following categories of improvement activities:

(a) *Financial Management Objectives.* Manager shall use commercially reasonable efforts to:

1. Organize the functions of revenue and receivables management, cash management, payroll and human resources management, capital management, supply chain management, reimbursement, budgeting, decision support, general accounting, including

accounts payable, purchasing and cashiering, and information technology services;

2. Prepare financial reports for the Health System and evaluate financial and cost reports for the Health System's Affiliates;

3. Prepare department operating budgets for purposes of maximizing operational efficiencies and propose for approval all budgets from the applicable Affiliate Board of Directors;

4. Monitor the financial and operating performance of any Health System activity;

5. Analyze and/or recommend changes as necessary with respect to the operating performance of Health System, and to permit income necessary to support Health System activities, and on behalf of Health System to supervise and direct the Health System's Affiliates in making such of those changes as are authorized or delegated by Health System or otherwise set forth in this Agreement and applicable bylaws of the Health System's Affiliates; and

6. Oversee third parties who may be retained to assist in expediting payment of overdue accounts.

(b) *Quality Assurance and Utilization Review.* Manager shall use commercially reasonable efforts with respect to the Health System to direct and oversee, and related to the Health System's Affiliates to provide analysis, expertise, advice, recommendations, and consultation to the Health System with respect to:

1. the Health System utilization management and quality assurance oversight mechanisms;

2. Education of Hospital physicians and Health System personnel concerning inappropriate utilization of care or delivery of medical services;

3. the Health System policies and procedures relating to the quality of patient care services as it relates to compliance with licensing and accreditation requirements;

4. the preparation and conduct of surveys by the Joint Commission and/or any other national, state or local agency; and

5. Management and improvement of quality indicators for core measures and HCAHPS, and develop effective means for communicating to the Health System feedback from the community and physicians regarding quality and effectiveness of the Health System's quality and patient satisfaction programs.

(c) *Health System Facilities and Infrastructure Improvements.* Manager shall use commercially reasonable efforts to:

1. Direct the Health System in the continuous and ongoing maintenance and repair of physical facilities in the Health System, including, without limitation, roofs, walls, HVAC systems, furniture and equipment, in order to maintain standards of operation at least equivalent to those prevailing as of the Effective Date, normal wear and tear excepted, which activities will include addressing any seismic compliance considerations; and

2. Direct the maintenance, improvements and strategies related to the Health System IT system and its components; and

3. Engage in long-term facilities planning with and for the Health System and the Health System's Affiliates.

1.6. Scope of Authority. Manager shall have the power and authority to do any and all actions that Manager determines, subject to the ultimate supervision of the Board of Directors of the Health System, but in consideration of any applicable reserved powers which may be held by the Health System as required by law or otherwise agreed by the parties, to be necessary, advisable, or proper, consistent with the terms of this Agreement and all applicable Laws, to provide the services pursuant to this Agreement to manage, administer or support the Health System. Nothing in this Agreement shall be deemed or interpreted to permit or cause the delegation or transfer of any responsibility or obligation required of, or by, the Board of Directors of the Health System or operational control of any of its Affiliates under applicable laws of the State of California or the United States of America. It is the Parties' intent to develop, adopt, and maintain in effect during the Term an appropriate authority matrix, which may change over time, as reasonable and necessary to carry out the purpose of this Agreement. As of the Effective Date, the Parties have agreed upon and adopted the System Authority Matrix attached hereto as Exhibit A (the "System Authority Matrix"). The System Authority Matrix shall be reviewed by the Parties on a periodic basis, not less frequently than once every three (3) years during the Term. Manager is hereby expressly authorized to subcontract for the provision of any of the Management Services that Manager performs under this Agreement; provided, however, that Manager may only subcontract or delegate Management Services to an affiliate of Manager with prior written notice to Health System and notwithstanding any such delegation or subcontract, Manager shall remain liable under the terms of this Agreement. Notwithstanding any provision to the contrary herein, Manager shall not delegate or subcontract any of its material obligations under this Agreement to any Person (including an affiliate of Manager) without the prior written consent of the Board of Directors of the Health System (which consent shall not be unreasonably withheld, conditioned, or delayed). Health System shall ensure that each Affiliate shall, from time to time, at Manager's request, execute and deliver, or cause to be executed and delivered, such further instruments or other documents, and perform such further acts, as Manager may reasonably require to fully perform the Management Services in accordance with this Agreement.

1.7. Confidentiality of Medical Records. Manager shall comply with all applicable Laws, all policies and procedures adopted by the Health System's Affiliates, and all state and federal rules and regulations in effect from time to time during the Term of this Agreement, regarding the confidentiality of patient medical records and information. Without limiting the foregoing: (a) each of the Parties agrees to comply with its obligations as a covered entity under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder by the Department of Health and Human Services ("HHS") (collectively, "HIPAA"), including the HIPAA Privacy Rule, 45 CFR Parts 160 and 164, the HIPAA Security Rule, 45 CFR Parts 160, 162 and 164, the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and regulations promulgated thereunder by HHS, including requirements related to security and privacy of patient information, and standard electronic transactions, code sets and identifiers; and (b) Manager agrees to comply with the obligations of the HIPAA Business Associate Addendum, executed by the Manager, the Health System and certain Affiliates on July 17, 2015, attached hereto as Exhibit B.

1.8. Ownership of Recorded Media. Except as expressly set forth herein, or in other written agreements between the Parties, neither Party shall acquire any ownership right or interest in any of the other Party's property, assets or interests, including such Party's software, databases, servers, hardware, or any other tangible or intangible property or assets (such as goodwill or going concern value) or any Affiliate's intellectual property or electronic patient records.

1.9. Report Requirements. Manager shall prepare and make available to Health System monthly reports for the Health System, including profit and loss statements, to be available to Health System by the 30th day of the following month. Year-end profit and loss statements, as well as information required for preparation of applicable tax returns, shall be available to Health System and, at Health System's direction, to its accountants prior to 45 days into the year following the year for which they are prepared. With the assistance of each Affiliate and necessary Health System personnel, Manager shall prepare and file on a complete and timely basis all reports, certificates, and other filings required under continuing disclosure agreements applicable to the Health System and under the Master Indenture of Trust, dated as of December 1, 2001, from Health System and the Initial Affiliates of the Obligated Group (as defined therein) to U.S. Bank Trust National Association, as amended and supplemented, and any other agreements relating to indebtedness of Health System. In addition, at the Health System's request, Manager shall make available to such Affiliate the following: (a) all required federal or state agency reports required in connection with the operation of the Health System; (b) all inspection reports, correspondence and notices from all state licensing agencies relating to the Health System; and (c) all correspondence and notices from all lenders and insurers relating to the Health System. Health System shall direct the Health System's Affiliates to provide: (i) payroll and quarterly tax reports; (ii) payroll information (including issuance of W-2s); and (iii) the items described at (a) through (c) in the foregoing sentence, within ten (10) days of Manager's receipt of same.

1.10. Manager Insurance. During the Term of this Agreement, Manager shall, at Manager's expense, maintain comprehensive general liability insurance coverage, written by a commercial carrier reasonably acceptable to Health System, with respect to its provision of

services at the Health System pursuant to this Agreement, with commercially reasonable limits of liability and either with a fidelity endorsement or a separate crime policy. Each Affiliate shall be named as an additional insured on any commercial liability insurance policies maintained by Manager hereunder, unless as set forth below, the insurance policy involved is a policy issued to the Health System on which Manager is a named insured. Manager shall provide Health System with a certificate evidencing the foregoing insurance coverage at the Effective Date, and shall not cancel such coverage without at least 30 days' prior written notice to the Health System. As an alternative to the foregoing requirements, Manager may elect to become a named insured on policies issued to Health System providing the same coverages as set forth above.

1.11. Health System Insurance. Health System and its Affiliates shall have obtained and shall maintain in full force and effect comprehensive general liability insurance coverage, written by a commercial carrier that would be reasonably acceptable to hospitals in California, with commercially reasonable limits of liability, which are not less than the limits which exist as of the Effective Date, and either with a fidelity endorsement or a separate crime policy, and shall maintain other adequate insurance for the Health System and its operations, including professional liability and malpractice coverage, director and officer liability coverage and fiduciary liability coverage. In the event Health System fails to obtain the insurance set forth in this Section 1.11, then Manager shall obtain this insurance consistent with the insurance referenced in Section 1.11 above.

ARTICLE II
REPRESENTATIONS AND WARRANTIES

2.1. General Capacity to Perform. Manager hereby represents and warrants to Health System that, and Health System (on behalf of its itself and each of the Health System's Affiliates for purposes of (a) and (b)) hereby represents and warrants to Manager that, it: (a) has the full power and authority to own its property and to carry on its business as now being conducted; (b) is duly qualified to do business in and is in good standing in the State of California; and (c) has the full power and authority to execute and deliver this Agreement and to perform and comply with its terms, conditions and agreements, all of which have been duly authorized by all proper and necessary corporate or limited liability company action, as applicable.

2.2. Specific Capacity to Perform. Manager hereby represents and warrants to Health System that, and Health System hereby represents and warrants to Manager that, this Agreement has been duly executed and delivered by its proper and authorized officers and constitutes the valid and legally binding obligation of such Party. Manager further represents and warrants, and Health System is relying upon such representation and warranty, that Manager possesses the skill, knowledge and resources required to fulfill its obligations under this Agreement. Further, Manager represents, warrants and covenants that it will at all times maintain all required governmental approvals required to perform the Management Services.

2.3. Compliance with Legal Requirements. Manager hereby represents and warrants to Health System that, and Health System (on behalf of its itself and each of the Health System's Affiliates) hereby represents and warrants to Manager that, it has and shall maintain throughout the Term of this Agreement all appropriate federal and state governmental approvals

which are required in order for such party to perform the services required of it under this Agreement. Health System further represents and warrants that each Affiliate is currently enrolled as a provider in good standing with the Medicare and Medi-Cal programs.

2.4. Government Payment Programs; Excluded Individuals. Manager hereby represents and warrants to Health System that, and the Health System (on behalf of itself and each of the Health System's Affiliates) hereby represents and warrants to Manager that, (a) it has not been suspended or excluded from participation in the Medicare or Medi-Cal programs or is otherwise subject to any restriction upon its participation therein, (b) no corporate affiliate or owner (as applicable), director, manager, officer, employee or contractor of such Party is, or is proposed to be, suspended, excluded from participation in, or sanctioned under, any federal or state health insurance program (including Medicare and Medicaid) (an "Excluded Individual"), (c) it has not been convicted of any criminal offense related to the delivery of any medical or health-related services or supplies, or related to the neglect or abuse of patients, and (d) it is not unable to obtain or maintain liability insurance consistent with commercially reasonable industry practices. The Health System (on behalf of its itself and each of the Health System's Affiliates) further represents and warrants that it has not received any notice of investigation by any governmental or regulatory agency in connection with its activities or those of the Hospitals as a provider under the Medicare and Medi-Cal programs.

2.5 Non-Interested Person Representation of Manager. Manager hereby represents that as of the Effective Date it has no financial interest and is not an "Interested Person" (as defined in Internal Revenue Service Form 1023) as it may relate to any third party contractor or vendor of the Health System or any Affiliate. Manager further represents that in the event Manager becomes an Interested Person during the Term of this Agreement, Manager shall make this disclosure to Health System.

ARTICLE III
LEGAL RESPONSIBILITIES

3.1. Staff Licenses. Health System shall ensure that all Employees as of the Effective Date shall have all appropriate licenses and certifications in the State of California and any medical or professional staff privileges at the Affiliates required in order for such Employees to perform the functions assigned to them by Health System.

3.2. Legal Compliance. Manager and Health System shall take all necessary steps to fully comply with the applicable Laws in the performance of their duties, powers and responsibilities hereunder, and shall seek to maintain such compliance at all times.

3.3. Monthly Debt Service Schedule. Health System shall provide Manager with a schedule of all principal and interest payments due with respect to indebtedness with respect to the Health System and the method for calculating interest with respect to such indebtedness.

ARTICLE IV
APPLICATION OF FUNDS; MANAGEMENT FEES

4.1. Application of Funds; Management Compensation.

4.1.1 Manager shall be entitled to receive compensation for the Management Services rendered pursuant to this Agreement based on a Management Fee Percentage ("MFP") equal to 4.00% based on consolidated financial statements for the Health System and the Affiliates ("Consolidated Statements") as follows ("Manager Compensation"):

(a) A fixed monthly fee for the period commencing on the Effective Date and ending on the last day of the fiscal year (the "Initial Year") in which the Effective Date occurs, equal to one-twelfth of the MFP of the greater of (i) Operating Revenues of the Health System for the trailing twelve (12) months as of June 30, 2015, or (ii) Operating Revenues for the trailing twelve (12) months as of October 31, 2015 (such monthly fee, as adjusted herein, the "Fixed Monthly Fee"). As of the first day of the fiscal year following the Initial Year and on the first day of each successive fiscal year thereafter, the Fixed Monthly Fee shall automatically adjust to equal the Fixed Monthly Fee in effect for the immediately prior fiscal year multiplied by one (1) plus the change from the immediately prior fiscal year in the greater of (x) the CPI, or (y) zero. Health System agrees to engage and consult with Deloitte & Touche LLP for the purpose of determining the Fixed Monthly Fee in accordance with this Section 4.1.1(a), which shall be subject to approval by the Health System's Board of Directors. Integrity and the Health System shall use commercially reasonable efforts to ascertain (and obtain Board of Director approval for) the Fixed Monthly Fee for the Initial Year on or before January 8, 2016.

4.1.2 For any period in respect of which Management Services are provided that is not a full month, the Manager Compensation shall be determined on a prorated basis according to the number of days in the month. Notwithstanding any provision to the contrary in this Agreement or the System Restructuring and Support Agreement, the pro-rated payment of the first Fixed Monthly Fee due under this Agreement shall be paid at the Closing (as defined under the System Restructuring and Support Agreement) (the "Initial Fixed Monthly Fee Payment"). The Initial Fixed Monthly Fee Payment, representing Manager Compensation that the Parties estimate will be earned by Manager for the period from the Effective Date through and including December 31, 2015, shall equal $1,450,000.00 and be reflected as such on the closing/settlement statement agreed to by Manager and Health System in connection with the Closing. Manager and Health System acknowledge and agree that the Initial Fixed Monthly Fee Payment is an estimate only and shall be subject to reconciliation on or before January 8, 2016 based on the actual Fixed Monthly Fee for the period commencing on the Effective Date and ending on December 31, 2015 as determined in accordance with Section 4.1.1(a).

4.1.3 Except as otherwise provided below, Manager Compensation shall be due and payable to Manager monthly in advance on the 10th day of each month during the Term.

4.1.4 Notwithstanding the foregoing, as of the Effective Date, the Fixed Monthly Fee will be deferred and paid as provided below.

(a) From the Effective Date and continuing thereafter through the Initial Year and the second fiscal year from the Effective Date:

1. To the extent the average Days' Cash on Hand over the ninety (90) day period ending on the final day of the most recent month preceding the date of payment for which month-end financial statements are available, after taking into account any payments made pursuant to this paragraph, exceeds fifteen (15) days, an amount equal to the product of (x) the Fixed Monthly Fee and (y) a fraction equal to 2.00% divided by the MFP will be payable in cash with the remaining amount of the Fixed Monthly Fee being deferred; however

2. To the extent the average Days' Cash on Hand over the ninety (90) day period ending on the final day of the most recent month preceding the date of payment for which month-end financial statements are available, after taking into account any payments made pursuant to this paragraph, does not exceed fifteen (15) days, an amount equal to the product of (x) the Fixed Monthly Fee and (y) a fraction equal to 1.00% divided by the MFP will be payable in cash with the remaining amount of the Fixed Monthly Fee being deferred; and

(b) Beginning the first day of the third fiscal year from the Effective Date:

1. To the extent the average Days' Cash on Hand over the ninety (90) day period ending on the final day of the most recent month preceding the date of payment for which month-end financial statements are available, after taking into account any payments made pursuant to this paragraph, exceeds fifteen (15) days, an amount equal to the product of (x) the Fixed Monthly Fee and (y) a fraction equal to 2.00% divided by the MFP will be payable in cash with the remaining amount of the Fixed Monthly Fee being deferred; however

2. To the extent the average Days' Cash on Hand over the ninety (90) day period ending on the final day of the most recent month preceding the date of payment for which month-end financial statements are available, after taking into account any payments made pursuant to this paragraph, does not exceed fifteen (15) days, an amount equal to the product of (x) the Fixed Monthly Fee and (y) a fraction equal to 1.00% divided by the MFP will be payable in cash with the remaining amount of the Fixed Monthly Fee being deferred; and

3. Upon the issuance of the audit for the most recently ended fiscal year but no later than 150 days after the end of the prior fiscal year, Operating Revenues over the sum of Cash Operating Expenses, Pension Funding Obligations, Capital Expenditures and Debt Service shall be calculated for that prior fiscal year, and, to the extent of any excess, all amounts currently deferrable or previously deferred pursuant to

paragraphs 4.1.4(a) and 4.1.4(b)(1-2) and not previously paid pursuant to this paragraph 4.1.4(b)(3) shall be paid to the extent of such excess. Any payments made pursuant to this subparagraph 3 shall be made only to the extent that the payment, does not result in Days' Cash on Hand going below fifteen (15) days. The calculation to be made under this subsection will be made not later than ten (10) business days following the issuance of the audit. Payments will be made within one business day of the approval of the Board of Directors of the Health System. If Fixed Monthly Fees are deferred for any particular period, they are considered for payment along with other accruing Fixed Monthly Fees in the next ensuing period for payment as follows: (i) Fixed Monthly Fees that are deferred under the provisions of Subsection (b)(3) above are only considered quarterly if the thresholds set forth therein have been met; and (ii) Fixed Monthly Fees deferred under the provisions of 4.1.4(a) and 4.1.4(b)(1) and (b)(2) will begin to accrue as set forth therein but only be considered for payment quarterly beginning in the third fiscal year after the Effective Date if the threshold set forth therein has been met.

4. Except for Fixed Monthly Fees that become due and payable pursuant to Section 4.1.4(b)(3) hereof, which shall be due and payable on a current basis at all times after such applicable threshold(s) has been met, other Fixed Monthly Fees deferred under the foregoing provisions of this Section 4.1.4 will be subordinated to all secured and unsecured payment obligations of the Health System, including funding obligations which represent pension underfunding, to the extent necessary to meet statutory requirements under ERISA.

5. The Manager shall report Days' Cash on Hand, the amount of the Fixed Monthly Fee, and the Fixed Monthly Fees deferred under Section 4.1.4, to the Board of Directors of Health System at the next regular meeting of such Board of Directors and prior approval of the Board of Directors of Health System shall be required prior to payment of any deferred Fixed Monthly Fees pursuant to Section 4.1.4(b)(3).

(c) All deferred Fixed Monthly Fees, to the extent not paid within the fiscal year in which earned, shall accrue interest from and after the first date of the next fiscal year at the rate of 2.82%. Such interest that accrues on deferred Fixed Monthly Fees in a fiscal year shall be added as of the last day of such fiscal year to the Fixed Monthly Fees to which it relates and subject to the payment and deferral provisions applicable to Fixed Monthly Fees for all purposes hereof.

(d) Except to the extent otherwise provided for in this Agreement, all deferred Fixed Monthly Fees (inclusive of all accrued interest thereon) accrued during the Term shall be due and payable at the end of the Term, if not paid sooner pursuant to the terms hereof.

(e) The Manager may elect to forfeit any Manager Compensation that would otherwise be deferred pursuant to paragraph (d) of this Section 4.1.4. The Manager may further

elect at any time to add any forfeited amounts to the Termination Fee or to the amounts deferred in a subsequent year.

(f) For the avoidance of doubt, as used in this Agreement, "fiscal year" is the fiscal year of Health System as set forth in the bylaws of Health System. As of the Effective Date, the fiscal year of Health System begins on the first day of July each year and ends on June 30th of the following year.

4.2. Certain Defined Terms. For purposes of this Agreement:

4.2.1 "Affiliates or Health System's Affiliates" shall mean the Hospitals and the related entities that support those entities: DCHS Medical Foundation, St. Francis Medical Center of Lynwood Foundation, St. Vincent Foundation, Saint Louise Regional Hospital Foundation, O'Connor Hospital Foundation, Seton Medical Center Foundation, Caritas Business Services, St. Vincent De Paul Ethics Corporation, St. Vincent Dialysis Center, Inc., Marillac Insurance Company, Ltd., De Paul Ventures, LLC, De Paul Ventures – San Jose ASC, LLC, and De Paul Ventures – San Jose Dialysis, LLC.

4.2.2 "Collection Quarter" shall mean any fiscal quarter falling within the Term of this Agreement, including the quarter during which the Agreement is terminated (regardless of whether termination occurs on the last day of a quarter).

4.2.3 "Days' Cash on Hand" shall mean, for any period, the quotient obtained by dividing (1) the Health System's cash and cash equivalents (including board designated funds and available borrowings on any revolving credit facility including, but not limited to, amounts eligible to be drawn under the 2015 Revenue Notes that are not subject to a condition that cannot be met on the testing date, but specifically excluding any unreleased portion of the Contribution (as that term is defined and described in Sections 2.1(k) and 2.1(l) of the System Restructuring and Support Agreement)) as of the end of the trailing twelve month period by (2) the quotient of dividing (a) the Health System's Cash Operating Expenses for the trailing twelve month period by (b) the number of days in such period.

4.2.4 "Operating Revenues" shall mean all net revenues recognized in the Consolidated Statements in accordance with GAAP and past practices on or after the Effective Date by the Health System including without duplication, revenues that relate to any and all presently existing and hereafter arising DSH Payments, Stabilization Funds, QAF Payments and Governmental Receivables (as defined below) and grants, including any of the foregoing that are attributable to the rendering of hospital inpatient and outpatient services or related supplies, devices and equipment, including diagnosis, treatment, technical and ancillary services ("Patient Services") during the Term of this Agreement, and irrespective of the source of payment or for the time period with which it may relate. Operating Revenue will not include any gain or loss resulting from either the early extinguishment or refinancing of indebtedness, or the sale, exchange or other disposition of capital assets not made in the ordinary course of business, adjustments to the value of assets or liabilities resulting from changes in generally accepted accounting principles, unrealized gains or losses that do not result in the receipt or expenditure of cash, charitable contributions and the interest earned thereon and nonrecurring items which do not involve the receipt, expenditure or transfer of assets. For the avoidance of doubt, Operating

Revenues shall include all revenues accounted for on the consolidated net revenues of the Health System which results from the deduction of contractual allowances, charity care, provisions for doubtful accounts and other items that the System has historically deducted from Gross Billings."

4.2.5 "Accounts Receivable" mean and include, in addition to the definition of accounts in the Uniform Commercial Code, any and all presently existing and hereafter arising accounts receivable, recoveries, refunds, counterclaims, claims of set-off and claims of Health System against payers and third persons relating thereto, and all other forms of obligations owing to Health System, without regard to dates of service before or after the Effective Date, whether known or unknown, matured or unmatured, accrued or contingent, that arise out of the provision of Patient Services or other services of the Health System at any time, including: (i) payments on a fee-for-service basis; (ii) payments on a capitated, case rate, percentage of premium basis, or any other prepaid basis; (iii) payments attributable to diagnostic imaging, testing or other ancillary services provided directly or under arrangements; (iv) risk sharing or gain sharing payments; (v) payments under policies of reinsurance; (vi) payments based on liens in cases of third party liability and workers' compensation; (vii) all Governmental Receivables that are assignable under applicable Laws; and (viii) the proceeds of all Governmental Receivables that are not assignable under applicable Laws.

4.2.6 "DSH Payments" mean and include payments owing to Health System under the Medi-Cal disproportionate share hospital program.

4.2.7 "QAF Payments" means any and all payments made to the Hospitals and any and all payments to which an Affiliate receives or is entitled to claim or receive under the Medi-Cal Hospital Quality Assurance Fee Program, as now existing or, as amended and superseded by any other California legislation, or any successor legislation which imposes a fee or tax on hospitals that is used to generated additional or supplemental Medi-Cal payments to hospitals and/or Medi-Cal managed care plans to be used for hospital services, including the Hospital Quality Assurance Fee Act of 2011 (California Welfare and Institutions Code, Chapter 7, Article 5.227) and any subsequent California legislation relating to QAF Payments.

4.2.8 "Retirement Plans" means the Daughters of Charity Health System Retirement Plan, the Daughters of Charity Health System Retirement Plan Account, the Daughters of Charity Health System Supplemental Retirement Plan (401(a)), the Daughters of Charity Health System Supplemental Retirement Plan (TSA/403(b)), and any other defined contribution plan that is listed on **Schedule 4.2.7** of the System Restructuring and Support Agreement (whether or not frozen).

4.2.9 "Multiemployer Plans" means the Local 39 Pension Plan and the Retirement Plan for Hospital Employees, as Amended and Restated Effective January 1, 2012 and as further amended.

4.2.10 "Stabilization Funds" mean and include any and all payments made to the Health System and any and all payments which the Health System receives or is entitled to claim or receive under the Medi-Cal Hospital Provider Rate Stabilization Act, as amended and superseded by any other California legislation, or any successor legislation which imposes a fee

or tax on hospitals that is used to generated additional or supplemental Medi-Cal payments to hospitals and/or Medi-Cal managed Health System plans to be used for hospital services, including but not limited to the Hospital Quality Assurance Fee Act of 2011 (California Welfare and Institutions Code, Chapter 7, Article 5.227) and any subsequent California legislation relating to stabilization payments.

4.2.11 "Governmental Receivables" mean and include all presently existing and hereafter arising Accounts Receivable, contract rights and all other forms of obligations owing from any Governmental Authority to Affiliates that arise out of the sale, lease, license or assignment of goods or other property, or the provision of Hospital Services or other services of the Health System, including any payments, grants or funds from Medicare, Medicaid or any other Governmental Authority.

4.2.12 "Operating Expenses" means, with respect to any period of time, all ordinary and necessary expenses incurred, in accordance with GAAP and past practices in the operation, management, administration and support of the Health System, including without duplication: (i) the cost of inventory, supplies and outside ancillary services furnished or obtained by Manager for the Health System and its Affiliates; (ii) the direct costs of billing and collection services on behalf of the Health System; (iii) the salaries, wages, employee benefits (including medical insurance where applicable), Social Security contributions, payroll taxes, workers' compensation insurance premiums and other amounts withheld for the Employees and contractors, including non-physician professional personnel; (iv) costs for utilities, including electricity, gas, water and telephone and obtaining other necessary services and supplies, whether purchased directly by Health System or provided by independent contractors, vendors, and other third parties, which shall include Manager; (v) costs of advertising and marketing performed on behalf of the Health System and its Affiliates; (vi) all insurance premiums, charges and other costs and expenses with respect to insurance covering the Health System and its Affiliates and the operations thereof, including liability, fire and casualty and extended coverage insurances; (vii) all expenses for maintenance and repair; (viii) administrative expenses; (ix) costs for the lease, rental or license of real or personal property (including payments with respect to intellectual property); (x) fees and costs for professional services, including the fees and expenses of attorneys, accountants and appraisers, incurred directly or indirectly in connection with any category of expense that is required to be capitalized in accordance with GAAP; and (xi) any interest expense. Operating Expenses will not include any gain or loss resulting from either the early extinguishment or refinancing of indebtedness, or the sale, exchange or other disposition of capital assets not made in the ordinary course of business, adjustments to the value of assets or liabilities resulting from changes in generally accepted accounting principles, unrealized gains or losses that do not result in the receipt or expenditure of cash and nonrecurring items which do not involve the receipt, expenditure or transfer of assets.

(a) "Cash Operating Expenses" shall mean all Operating Expenses per section 4.2.12 less any depreciation and amortization expense and deferred Fixed Monthly Fees included in Operating Expenses.

(b) "Capital Expenditures" means capital expenditures approved as a part of the capital budget and either expended or reserved within the fiscal year, which will not be less than Forty Million dollars ($40,000,000) during each of the first three calendar years,

commencing the January 1 following the Closing, and for the ensuing years of the Management Agreement, not less than Thirty Million dollars ($30,000,000) per calendar year except as such amounts are adjusted pursuant to Section 7.7 of the System Restructuring and Support Agreement. Notwithstanding any provision to the contrary in this Agreement, any Capital Expenditures designated as (1) growth capital expenditures, which shall be designated as such in the Health System Board of Director's approval of the project, or (2) capital expenditures associated with mergers or acquisitions, shall not be included in the calculation of positive cash flow in Section 4.1.4(b)(3)).

(c) "Pension Funding Obligations" shall mean payments legally required by the Employee Retirement Income Security Act of 1974, as amended, or an applicable collective bargaining agreement, if any, pertaining to the Health System's funding obligations under the Retirement Plans and Multiemployer Plans, as applicable, as well as any insurance premiums required by the Pension Benefit Guaranty Corporation and payable by the Health System with respect to the Retirement Plans. To the extent that any of these amounts are included in Cash Operating Expenses, if at all, such amounts shall be excluded from Pension Funding Obligations for purposes of this Agreement.

4.2.13 "Debt Service" shall include all required principal amortization payments on the Health System's 2005 Bonds, as well as any interest expense actually paid in cash with respect to Health System indebtedness not already included in Cash Operating Expenses.

4.2.14 "CPI" shall mean the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items, as published by the Bureau of Labor Statistics of the U.S. Department of Labor.

4.2.15 "System Restructuring and Support Agreement" shall mean the System Restructuring and Support Agreement, by and between Health System, Daughters of Charity Ministry Services Corporation, certain funds managed by Blue Mountain Capital Management, LLC and Manager, dated July 17, 2015, as amended by that certain Amendment No.1, dated September 18, 2015, and that certain Amendment No.2, dated December 14, 2015.

4.2.16 "2015 Revenue Notes" means the California Public Finance Authority Revenue Notes (Verity Health System), Series 2015A, Series 2015B, Series 2015C and Series 2015D.

4.2.17 "Consolidated Statements". For purposes of Section 4.1 and Section 4.2, references to financial results of the "Health System" shall mean and include the consolidated results of operations as reported in the consolidated (or consolidating, as applicable) statements of the Health System and its Affiliates.

4.3. Interest. If any fee or other amount due by Health System to Manager under this Agreement is not paid within thirty (30) days after such payment is due (excluding any Fixed Monthly Fees that are deferred in accordance with Section 4.1.4 of this Agreement), at the election of the Manager, such amount shall bear interest from and after the respective due dates thereof until the date on which the amount is received in the bank account designated by Manager to which such amount is owed at an annual rate of interest equal to the lesser of (a) the

prevailing lending rate of Manager's principal bank for working capital loans to Manager at LIBOR plus three percent (3%) and (b) the highest rate permitted by applicable Law.

ARTICLE V
TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on the Effective Date and continue through the day immediately preceding the fifteenth (15^{th}) anniversary of the Effective Date (such period, the "Initial Term"), unless terminated earlier in accordance with the terms of this Agreement. At the end of the Initial Term, this Agreement shall automatically renew for a five (5) year term (each a "Renewal Term") unless either Party notifies the other Party at least one hundred eighty (180) days prior to the end of the Initial Term that it does not wish to renew (an "Renewal Denial") the Agreement. The Initial Term, together with any Renewal Terms, are referred to collectively as the "Term." The "Effective Date of Termination" shall be the effective date of the termination of this Agreement, as determined in accordance with the provisions of this Article V.

5.2. Termination for Cause by Health System. Health System shall have the right to terminate this Agreement at any time if there shall be Cause that is not cured within any applicable cure period set forth in this Section 5.2 and provided that Health System affords Manager an opportunity for discussion immediately following delivery of notice to Manager of Cause. The following shall constitute Cause for purposes of this Section 5.2:

(a) (i) Any willful or negligent systematic act or omission by Manager that imminently jeopardizes or places at risk the health, safety or welfare of patients of the Health System or any Affiliate; or (ii) any act or omission by Manager that jeopardizes or places at risk the health, safety or welfare of patients in the Health System or any Affiliate, but not in an imminent manner, shall constitute a material breach of this Agreement and shall be grounds for termination subject in each case to a 30 day cure period; *provided, however*, that in the event there is Cause under Section 5.2(a)(i), the Chair of the Board of the Health System and any other Board member of the Board of the Health System, the Chair of the Board of any affected Affiliate, the CEO of Health System, the CEO of the affected Affiliates, and the representatives of BlueMountain and Manager shall promptly meet to discuss the act or omission and consequences thereof and if the CEO of Health System and the Chair of the Board of the Health System of the affected Affiliate(s) are not satisfied with Manager's immediate response to such act or omission, or consequence thereof, then the Health System may take such corrective actions as it deems necessary to protect the health, safety, or welfare of the patients of the Health System or any Affiliate and Manager agrees to reimburse the Health System or any Affiliate for its reasonable costs and expenses incurred in connection with such corrective action.

(b) (i) Any willful conduct by Manager that imminently jeopardizes any certifications or accreditations of the Health System or any Affiliate; or (ii) any willful conduct by Manager that jeopardizes any certifications or accreditations of the Health System or any Affiliate, but not in an imminent manner, shall constitute a material breach of this Agreement and shall be grounds for termination subject in each case to a ninety (90) day cure period; *provided, however*, that if Manager has used best efforts to cure said material breach, and such material breach is not amenable to cure within said ninety (90) day period, Manager may

continue such efforts to the extent reasonably necessary to afford Manager reasonable opportunity to cure said material breach with the consent of the Board of the Health System (such consent not to be unreasonably withheld); *provided further, however*, that in the event there is Cause under Section 5.2(b)(i) or (ii), the Chair of the Board of the Health System and any other Board member of the Board of the Health System, the Chair of the Board of any affected Affiliate, the CEO of Health System, the CEO of the affected Affiliates, and the principals of BlueMountain and Manager shall promptly meet to discuss the conduct and consequences thereof, and if the CEO of Health System and the Chair of the Board of the Health System and the affected Affiliate(s) are not satisfied with Manager's immediate response to such conduct or consequence thereof, then the Health System may take such corrective actions as it deems necessary to preserve and maintain the certifications or accreditations of the Health System or any Affiliate and Manager agrees to reimburse the Health System or any Affiliate for its reasonable costs and expenses incurred in connection with such corrective action.

(c) (i) Any illegal conduct by Manager that imminently jeopardizes any necessary certification, permit, consent and approval to operate the Health System or the Affiliates and/or receive reimbursement for medical goods and services provided at any Hospitals or other locations of the Health System's Affiliates; or (ii) any illegal conduct by Manager that jeopardizes, but not in an imminent manner, any necessary certification, permit, consent and approval to operate the Health System or any Affiliate and/or receive reimbursement for medical goods and services provided at the Hospitals or other locations of the Health System's Affiliates, shall constitute a material breach of this Agreement and shall be grounds for termination subject in each case a ninety (90) day cure period; *provided, however*, that if Manager has used best efforts to cure said material breach, and such material breach is not amenable to cure within said ninety (90) day period, Manager may continue such efforts to the extent reasonably necessary to afford Manager reasonable opportunity to cure said material breach with the consent of the Board of the Health System (such consent not to be unreasonably withheld); *provided further, however*, that in the event there is Cause under Section 5.2(c)(i), the Chair of the Board of the Health System and any other Board member of the Board of the Health System, the Chair of the Board of any affected Affiliate, the CEO of Health System, the CEO of the affected Affiliates, and the representatives of BlueMountain and Manager shall promptly meet to discuss the conduct and consequences thereof, and if the CEO of Health System and the Chair of the Board of the Health System and the affected Affiliate(s) are not satisfied with Manager's immediate response to such conduct or consequence thereof, then the Health System may take such corrective actions as it deems necessary to preserve and maintain any necessary certification, permit, consent and approval to operate the Health System or any Affiliate and/or receive reimbursement for medical goods and services provided at any Hospitals or other locations of the Health System's Affiliates and Manager agrees to reimburse the Health System or any Affiliate for its reasonable costs and expenses incurred in connection with such corrective action.

(d) Willful or persistent failure or refusal to perform Manager's material obligations under the Agreement for thirty (30) days after written notice thereof from Health System;

(e) A material breach or default by Manager of any representation and warranty, duty, obligation or covenant made by Manager, and such material breach or default is

not materially cured within thirty (30) days after the provision of written notice of such breach or default by Health System; provided, however, that if Manager has taken all reasonable steps necessary to cure said material breach or default, and such material breach or default is not amenable to cure within said thirty (30) day period, Health System shall extend the cure period on a month-by-month basis to the extent reasonably necessary to afford Manager reasonable opportunity to cure said material breach or default, but in no event for a period of longer than ninety (90) consecutive days: provided, however, that if the material breach or default under this Agreement consists of or results in material breach or default of a material obligation to any third party or material violation of a legal obligation, then the material breach or default under this Agreement shall be subject to cure only if and to the extent that the material breach or default of the third party obligation or legal obligation is subject to cure;

(f) Any governmental or regulatory agency gives notice of any formal action to cause a Medicare decertification of a Hospital or any other location of the Affiliates, or notice of any intent to do so (collectively, "Government Action") based on activities that occurred after the Effective Date which were the direct result of conduct by the Manager, or the failure of Manager to take appropriate remedial action after the Effective Date, and any available pre-termination appeals are exhausted;

(g) Any Governmental Authority obtains a final, non-appealable, decision of a court or other arbiter that causes the loss of the tax-exempt status of the Health System or any Affiliate under §501(c)(3) of the Internal Revenue Code of 1986, as amended, due to the acts or omissions of Manager or existence of this Agreement, provided that Manager fails to initiate corrective action to bring the Health System or Affiliate back into compliance with tax-exempt status under §501(c)(3) of the Internal Revenue Code of 1986, as amended, within 30 days of issuance of such decision; *provided, further*, that loss of the tax-exempt status of the Health System or any Affiliate under §501(c)(3) of the Internal Revenue Code of 1986, as amended, due to the conversion of any or all Affiliates to for-profit entities after the sale of assets of the Health System pursuant to the exercise of a purchase option under either of the Option Agreements, shall not constitute "Cause" under this Section 5.2(g).

(h) Any Governmental Authority or the trustee with respect to the Revenue Bonds obtains a final, non-appealable, decision of a court or other arbiter, with respect to the Revenue Bonds, that there is or has been a material breach of the related loan agreement, regulatory agreement or indenture or that the interest payments on the Revenue Bonds will no longer be excluded from gross income for federal income tax purposes under § 103 of the Internal Revenue Code of 1986, as amended, as the result of acts or omissions of the Manager or existence of this Agreement, provided that there shall be no "Cause" under this Section 5.2(h) if, within 30 days of the issuance of such decision, Manager has taken initiated corrective action to bring the Revenue Bonds back into compliance with such related loan agreement, regulatory agreement, or indenture, or under § 103 of the Internal Revenue Code of 1986, as amended, including but not limited to, by replacing or refinancing the Revenue Bonds; *provided, further*, that a final non-appealable decision described under this Section 5.2(h) arising from or related to the conversion of any or all Affiliates to for-profit entities after the sale of assets of the Health System pursuant to the exercise of a purchase option under either of the Option Agreements, shall not constitute "Cause" under this Section 5.2(h).

(i) Any employee or contractor of Manager working at or on behalf of the Health System is or becomes an Excluded Individual, and, upon learning of such status Manager does not immediately terminate such employee or contractor or transfer such employee or contractor out of the Health System; and

(j) Manager shall materially default in the performance of any covenant, agreement, term or provision of this Agreement to be kept, observed or performed by Manager, and such material default shall continue for a period of sixty (60) days after written notice is given to Manager by Health System stating the specific default; provided a cure may reasonably be affected in sixty (60) days. If it cannot, then Manager must be taking all reasonable steps to effect a cure as quickly as possible thereafter, but in any event such cure must be materially performed within one hundred and twenty (120) days; provided, however, that if the material breach or default under this Agreement consists of or results in breach or default of an obligation to any third party or violation of a legal obligation, then the breach or default shall be subject to cure only if and to the extent that the breach or default of the third party obligation or legal obligation is subject to cure.

5.3. Termination for Cause by Manager. Manager may elect at its sole and absolute discretion to terminate this Agreement for Cause pursuant to this Section 5.3 upon the date specified in Manager's written notice to Health System in respect thereof. The following shall constitute Cause for purposes of this Section 5.3:

(a) A breach of any of Health System's representations and warranties set forth in Article II;

(b) The filing by or against Health System or any of its Affiliates of any proceeding under the federal bankruptcy law, foreclosure laws or the insolvency law of any state or foreign jurisdiction;

(c) Any conviction of Health System or any of its Affiliates for illegal conduct that imminently jeopardizes any of the necessary Licenses to operate the Health System and/or receive reimbursement for medical goods and services provided at the Health System;

(d) Any Affiliate's failure, at the direction of the Health System, to remove any officer of such Affiliate who is an Excluded Individual within ten (10) business days following actual knowledge by any Affiliate;

(e) Any Affiliate's failure, at the direction of the Health System, to cooperate and support in good faith Manager's performance pursuant to this Agreement, subject to the proviso in this Section 5.3;

(f) Any Government Action based solely on activities of Health System that occurred before or after the Effective Date;

(g) Any Governmental Authority undertakes any action or requests that a receiver be appointed with respect to the operation of the Health System for the purpose of replacing any Affiliate as the owner of its portion of the Health System based solely on the activities of any Affiliate that occurred before or after the Effective Date;

(h) Disagreement between Health System and Manager concerning a material operational, financial, or legal issue which is not amenable to resolution following good faith negotiations between Health System and Manager, during the period extending for up to sixty (60) days following written notice of a Dispute and compliance with the Meet and Confer Obligations set forth herein; or

(i) A material breach or default by Health System of any obligation or covenant of Health System under this Agreement, and such material breach or default is not cured within thirty (30) days after the provision of written notice of such breach or default by Manager; provided, however, that if Health System has taken all reasonable steps necessary to cure said material breach or default, and such material breach or default is not amenable to cure within said thirty (30) day period, Manager shall extend the cure period on a month-by-month basis to the extent reasonably necessary to afford Health System reasonable opportunity to cure said material breach or default; provided, further, that if the material breach or default consists of or results in material breach or default of a material third party obligation or material violation of a legal obligation, then the breach or default by Health System of this Agreement shall be subject to cure only if and to the extent that the material breach or default of the third party obligation or legal obligation is subject to cure;

provided that, notwithstanding the above, in the event of any such actions as those described in paragraphs (a) through (g) above, Health System shall be entitled to a period of thirty (30) days within which to cure said action, commencing after the provision of written notice by Manager to Health System; provided, however, that if Health System has taken all reasonable steps necessary to cure and/or resolve such actions, and the same is not amenable to cure within said thirty (30) day period, the Parties shall extend the cure period on a month-by-month basis to the extent reasonably necessary to afford Health System reasonable opportunity to cure the same.

5.4. At Will Termination by Manager or Health System.

5.4.1 Absent "Cause" under Section 5.2, Health System may terminate this Agreement at any time with 90-days' prior written notice to Manager, following a compliance with the Meet and Confer obligation, provided that Health System shall pay to Manager: (i) all Manager Compensation (including any interest accrued thereon) and other fees or reimbursable expenses accrued and payable to the Manager prior to the Effective Date of Termination; and (ii) a termination fee equal to the present value of the Manager Compensation that, in the absence of termination of the Agreement, would be payable to Manager from the date of the noticed termination through the remainder of the Initial Term exclusive of any Renewal Term (the "Termination Fee"). For purposes of determining the Termination Fee: the annual increase to the Fixed Monthly Fee provided for under Section 4.1.1(a) for each of the years remaining in the Term shall be applied and set at an amount equal to the average of the annual rate of increase applied for the years of the Term from the Effective Date to the end of the year immediately preceding the Effective Date of Termination.

5.4.2 Absent "Cause" under Section 5.3, Manager may terminate this Agreement at any time with 150-days' prior written notice to Health System; *provided, however*, that Manager shall forfeit the right to receive any Fixed Monthly Fees that are deferred in accordance with Section 4.1.4 of this Agreement.

5.5. Termination upon Option Exercise. This Agreement shall automatically terminate upon the closing of the purchase and sale of Health System's and its Affiliates' assets pursuant to exercise of the option granted under either of the Option Agreements.

5.6. Effect of Termination. As of the Effective Date of Termination of this Agreement, all rights and obligations accruing prior to such Effective Date of Termination shall remain in full force and effect, including all rights and obligations arising as a result of any termination of this Agreement pursuant to this Article V and Section 5.7 in particular. Furthermore, the following provisions shall survive the expiration or other termination of this Agreement, regardless of the cause of such termination: Sections 1.1.2 and 1.10; Sections 2.2 and 2.3; Article IV; Section 5.4, this Section 5.5, and Sections 5.6, 5.7, 5.8 and 5.9; Article VI; Article VII; Article VIII; and Sections 9.1, 9.2, 9.3, 9.4, 9.5, 9.6, 9.9, 9.10, 9.11, 9.12, 9.14, 9.15 and 9.16.

5.7. Payments Upon Termination for Cause.

5.7.1 Upon any termination of this Agreement by the Health System for Cause under Sections 5.2(a), 5.2(b), 5.2(c) and 5.2(d), Manager shall forfeit any right to receive Manager Compensation that has accrued but not yet been paid as of the noticed date of termination.

5.7.2 Upon termination of this Agreement by the Health System under Sections 5.2(e) through (j), Health System shall remain obligated to compensate Manager for all expenses and fees (including accrued expenses and fees) due and owing Manager by the Health System including Manager's fees as set forth in Article IV (for the avoidance of doubt, including any prorated amounts pursuant to Section 4.1.2).

5.7.3 Upon any termination of this Agreement by Manager for Cause under Section 5.3, Health System shall remain obligated to compensate Manager for all expenses and fees (including accrued expenses and fees) due and owing Manager as of the Effective Date of Termination of this Agreement, including Manager's fees as set forth in Article IV (for the avoidance of doubt, including any prorated amounts pursuant to Section 4.1.2). In addition to the foregoing, Manager shall be entitled to pursue its damages or any other remedies to which it is entitled under State or federal law.

5.8. Transition of Management Upon Termination. Upon the expiration or earlier termination of this Agreement, Manager and Health System shall use commercially reasonable efforts to arrange for transition management of the Health System to the Health System or its designee in a safe and orderly manner, with the primary goal of avoiding jeopardy to the health and safety of all patients of the Health System and the Affiliates. Manager shall be entitled to rely with certainty that Health System or its designee shall assume management of the Health System as of the Effective Date of Termination. Health System shall be responsible for the Operating Expenses of the Health System accruing on and after the Effective Date of Termination.

5.9. Payment to Manager by Health System. Within fifteen (15) days from the Effective Date of Termination pursuant to this Article V, Health System shall pay Manager all amounts owing pursuant to this Agreement.

5.10. No Other Early Termination. This Agreement may only be terminated prior to the expiration of the Term as provided in this Article V.

ARTICLE VI
INDEMNITIES

6.1. Indemnity by Manager. Subject to Sections 6.3 and 6.4, Manager shall indemnify and hold Health System, each Affiliate and its directors, officers, employees, agents, and representatives (the "Health System Indemnified Parties") harmless from any and all liabilities, obligations, claims, causes of action, contingencies, damages, costs, and expenses (including all court costs and attorneys' fees, whether as a result of direct claims or third party claims that the Health System Indemnified Parties or any of them may suffer or incur) of any nature to the extent directly caused by a specific act or omission of Manager in its performance of the Management Services. Except for Manager's indemnification obligations set forth in Article VI, as between Health System's Affiliates and Manager, Manager will have no liability for monetary damages or monetary relief to any Affiliate for any violation of Manager's Standard of Care or claims of breach of any fiduciary duties or duties as agent unless such violation or breach was due to Manager's Gross Negligence or Willful Misconduct. For purposes hereof: "Operating Limitations" means (a) the requirements and limitations on Manager set forth in this Agreement, (b) any provisions of any contracts or other agreements relating to the Revenue Bonds limiting or otherwise imposing conditions on the assets or operation of the Health System or Affiliate; (c) any limitation or conditions arising under applicable Laws; and (d) the business plan relating to the Health System or Affiliate as may be developed by Manager and Health System from time to time and adopted by the board of directors of Health System; and "Manager's Gross Negligence or Willful Misconduct" means any gross negligence in the performance of Manager's duties under this Agreement or willful misconduct or fraud committed by Manager or its affiliates with respect to the Health System or any Affiliate, provided that (a) the acts or omissions of the Employees (as defined below) shall not be imputed to Manager or its affiliates, or otherwise deemed to constitute Manager's Gross Negligence or Willful Misconduct, unless such acts or omissions resulted from the gross negligence, willful misconduct or fraudulent acts of Manager in supervising such Employees, and (b) no settlement by any Party in good faith of any claims (including claims by the Employees) shall be deemed to create any presumption that the acts or omissions giving rise to such claims constitute Manager's Gross Negligence or Willful Misconduct.

6.2. Indemnity by Health System. Subject to Sections 6.3 and 6.4, Health System and each Affiliate shall indemnify and hold Manager and its directors, officers, employees, agents, and representatives (the "Manager Indemnified Parties") harmless from any and all liabilities, obligations, claims, causes of action, contingencies, damages, costs, and expenses (including all court costs and attorneys' fees, whether as a result of direct claims or third party claims that the Manager Indemnified Parties or any of them may suffer or incur) of any nature, that are not within the scope of Manager's indemnification pursuant to Section 6.1, except to the extent caused by the gross negligence of any Manager Indemnified Parties.

6.3. Waiver of Liability. AS LONG AS A PARTY IS A NAMED INSURED OR ADDITIONAL INSURED UNDER THE OTHER PARTY'S INSURANCE POLICIES, OR THE POLICIES OTHERWISE PERMIT IF SUCH PARTY IS NOT SO NAMED, SUCH PARTY HEREBY RELEASES THE OTHER PARTY AND ITS AFFILIATES AND ITS AND THEIR TRUSTEES, BENEFICIARIES, DIRECTORS, OFFICERS, EMPLOYEES AND AGENTS, AND THE SUCCESSORS AND ASSIGNS OF EACH OF THE FOREGOING, FROM ANY AND ALL LIABILITY FOR MONETARY RELIEF, DAMAGE, LOSS, COST OR EXPENSE INCURRED BY THE RELEASING PARTY, WHETHER OR NOT DUE TO THE NEGLIGENT OR OTHER ACTS OR OMISSIONS OF THE PERSONS SO RELEASED TO THE EXTENT SUCH LIABILITY, DAMAGE, LOSS, COST OR EXPENSE IS COVERED BY THE INSURANCE POLICIES OF THE RELEASING PARTY, BUT ONLY TO THE EXTENT OF INSURANCE PROCEEDS RECEIVED.

6.4. Special Damages. Other than liability for third party claims, no Party shall have any liability for any punitive, incidental, consequential, special or indirect damages, loss of future profits, revenue or income, diminution in value or loss of business reputation or opportunity relating to the breach or alleged breach of this Agreement, regardless of whether such losses were foreseeable.

6.5. Indemnification Procedures. The indemnifying Party shall have the right to assume the defense of any claim with respect to which the indemnified Party is entitled to indemnification hereunder. If the indemnifying Party assumes such defense: (a) such defense shall be conducted by counsel selected by the indemnifying Party and approved by the indemnified Party, such approval not to be unreasonably withheld or delayed (provided, that the indemnified Party's approval shall not be required with respect to counsel designated by the indemnifying Party's insurer); (b) so long as the indemnifying Party is conducting such defense with reasonable diligence, the indemnifying Party shall have the right to control said defense and shall not be required to pay the fees or disbursements of any counsel engaged by the indemnified Party except if a material conflict of interest exists between the indemnified Party and the indemnifying Party with respect to such claim or defense; and (c) the indemnifying Party shall have the right, without the consent of the indemnified Party, to settle such claim, but only if such settlement involves only the payment of money, the indemnifying Party pays all amounts due in connection with or by reason of such settlement and, as part thereof, the indemnified Party is unconditionally released from all liability in respect of such claim. The indemnified Party shall have the right to participate in the defense of such claim being defended by the indemnifying Party at the expense of the indemnified Party, but the indemnifying Party shall have the right to control such defense (other than in the event of a material conflict of interest between the parties with respect to such claim or defense). In no event shall (i) the indemnified Party settle any claim without the consent of the indemnifying Party so long as the indemnifying Party is conducting the defense thereof in accordance with this Agreement or (ii) if a claim is covered by the indemnifying Party's insurance, knowingly take or omit to take any action that would cause the insurer not to defend such claim or to disclaim liability in respect thereof.

6.6. No Warranty. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, NO PARTY MAKES OR HAS MADE ANY REPRESENTATION OR WARRANTY, EXPRESS OR IMPLIED, AT LAW OR IN EQUITY, IN RESPECT OF THE MANAGEMENT SERVICES, INCLUDING WITH RESPECT TO (I) MERCHANTABILITY

OR FITNESS FOR ANY PARTICULAR USE OR PURPOSE OR (II) THE PROBABLE SUCCESS OR PROFITABILITY OF THE HEALTH SYSTEM AFTER THE RECEIPT OF THE MANAGEMENT SERVICES.

6.7. Dispute Resolution; Exclusive Remedy.

(a) In the event of any dispute, controversy, claim, or disagreement arising out of or relating to this Agreement or the acts or omissions of the Parties with respect to this Agreement (each, a "Dispute"), the Parties shall resolve such Dispute as set forth in this Section.

(b) The Parties shall, after one Party gives written notice of a Dispute to the other Parties (the "Dispute Notice"), meet and confer in good faith in at least two separate sessions that include representatives of each Party with the authority to resolve the Dispute, regarding such Dispute at such time and place as mutually agreed upon by the Parties (the "Meet and Confer"). The Parties shall conduct such Meet and Confers as soon as reasonably practicable, but in no event later than thirty (30) days after the date of the Dispute Notice. Each Meet and Confer shall include the CEO of the Health System, the Chair of the Board of Health System and the Chair of the Board of any directly affected Affiliate, and a Member of the Board of Manager, who shall be the Chair of the Board of the Manager, unless the Chair is the Health System CEO, and a representative of BlueMountain Capital Management, LLC, and shall take place at the principal office of the Manager during normal working hours. If a Party fails to comply with this obligation to Meet and Confer within 5 business days from receipt of the Dispute Notice, then that Party shall be deemed to have waived this requirement.

(c) If any Dispute is not resolved to the mutual satisfaction of the Parties within sixty (60) days after delivery of the Dispute Notice (or such other period as may be mutually agreed upon by the Parties in writing), any Party may submit such Dispute to mandatory arbitration conducted by the American Arbitration Association ("AAA") in Los Angeles, California in accordance with the commercial complex litigation arbitration rules of the AAA.

(d) Any Party may apply to a court of competent jurisdiction for entry and enforcement of judgment based on the arbitration award. The award of the arbitrator shall be final and binding upon the Parties without appeal or review except as permitted by the Arbitration Act of the State of California.

(e) The fees and costs of the arbitration, including any costs and expenses incurred by the AAA in connection with the arbitration, shall be borne equally by the Parties, unless otherwise agreed to by the Parties.

(f) Except as set forth in subparagraph (e) above, each Party shall be responsible for the costs and expenses incurred by such Party in connection with the arbitration, including its own attorney's fees and costs; provided, however, that the AAA shall require the claiming Party to pay the costs and expenses of the other Party, including attorneys' fees and costs and the fees and costs of experts and consultants, incurred in connection with the arbitration if the AAA determines that the claims and/or causes of action brought by the Party submitting the Dispute to arbitration were frivolous and without reasonable foundation.

(g) This Article VI shall provide the exclusive remedy for the Parties for any dispute, misrepresentation or breach of warranty or covenant or for any claim which may arise out of this Agreement or the transactions described herein.

ARTICLE VII
NOTICE

Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and will be deemed effectively delivered when personally delivered or when actually received by recognized overnight courier, addressed as follows:

If to Health System:

Verity Health System of California, Inc.
203 Redwood Shores Parkway, #800
Redwood Shores, CA 94065-1159
Telephone number: (310) 498-6157
Attention: President and Chief Executive Officer

With a copy (which shall not constitute notice) to:

Ropes & Gray LLP
3 Embarcadero Center, Suite 300
San Francisco, California 94111
Telephone number: 415-315-6394
Facsimile number: 415-315-4801
Attention: John O. Chesley, Partner

If to Manager:

Integrity Healthcare, LLC
2200 West Third Street, Suite 200
Los Angeles, CA 90057
Telephone number: (310) 498-6157
e-mail: creem@integrityhci.com
Attention: Mitch Creem

With a copy (which shall not constitute notice) to:

Foley & Lardner LLP
111 Huntington Ave., Suite 2600
Boston, MA 02199-7610
Telephone number: (617) 342-4055
Facsimile number: (617) 342-4001
Attention: J. Mark Waxman, Partner

With a copy (which shall not constitute notice) to:

BlueMountain Capital Management, LLC
280 Park Avenue, 12th Floor
New York, NY 10017
Telephone number: 212-905-2184
email: legalnotices@bmcm.com
Attention: Richard Horne, Associate General Counsel, Tax

or to such other address, or to the attention of such other Person, as any Party may designate by notice delivered in like manner.

ARTICLE VIII
INDEPENDENT CONTRACTOR

In entering into this Agreement, and in acting in compliance herewith, Manager is at all times acting and performing as an independent contractor duly authorized to perform the services required of it hereunder as an agent of Health System. Nothing contained in this Agreement or any agreements, instruments, documents or transactions contemplated hereby shall constitute or be construed to create a partnership, joint venture, general agency, or similar relationship between Health System, or its successors or permitted assigns, and Manager, or its successors or permitted assigns. The Parties acknowledge and agree that (a) Manager shall have the authority to bind Health System with respect to third Persons to the extent Manager is performing its obligations under and consistent with this Agreement; (b) Manager's agency established with the Health System is, and is intended to be, an agency coupled with an interest; and (c) in performing the Management Services, (i) Manager assumes no independent contractual liability and (ii) Manager shall have no obligation to extend its own credit with respect to any obligation incurred in operating the Health System or performing its obligations under this Agreement.

ARTICLE IX
MISCELLANEOUS

9.1. Waiver. The waiver by a Party of any breach of any term, covenant or condition herein contained shall not be deemed to be a continuing waiver of such term, covenant or condition or any subsequent breach of the same or any other term, covenant or condition herein contained. The subsequent acceptance by a Party of performance by the other shall not be deemed to be a waiver of any preceding breach of any term, covenant or condition of this Agreement, other than the failure to perform the particular duties so accepted, regardless of knowledge of such preceding breach at the time of acceptance of such performance.

9.2. Prevailing Party. If any litigation or other court action, arbitration or similar adjudicatory proceeding is commenced by any Party to enforce its rights under this Agreement against any other Party, all fees, costs and expenses, including reasonable attorneys' fees, court costs and other expenses, incurred by the prevailing Party in such litigation, action, arbitration or proceeding shall be reimbursed by the losing Party; provided, that if a Party to such litigation, action, arbitration or proceeding prevails in part, and loses in part, the court, arbitrator or other

adjudicator presiding over such litigation, action, arbitration or proceeding shall award a reimbursement of the fees, costs and expenses incurred by such Party on an equitable basis.

9.3. Binding Nature of Agreement. Subject to Section 9.5 below, this Agreement shall be binding upon and shall be for the benefit of the Parties hereto and their respective permitted successors and assigns.

9.4. Entire Agreement. This Agreement and all exhibits referenced herein and attached hereto, contain the entire agreement between the Parties relating to the subject matter contained herein, and supersede any prior oral or written communication between them concerning its terms. Any waiver or modification of this Agreement shall be effective only if in writing and signed by the Party against whom such waiver or modification is sought to be enforced.

9.5. Assignability. Health System may not assign either this Agreement or any of its rights, interests or obligations hereunder without the prior written approval of Manager. Manager may assign any or all of its rights, interests and obligations hereunder to one or more of its affiliates or to any other Person (including as expressly provided in Section 1.6 with respect to subcontracting), subject to the requirement of prior written consent of the Board of Directors of Health System set forth under Section 1.6.

9.6. Preparation of Agreement. Each of the Parties acknowledges that they have had an opportunity to obtain counsel of their own choosing, and that both of them have read this Agreement, understand the terms used herein, and consequences thereof and that they have freely and voluntarily entered into this Agreement. Each of the Parties is willing to and does hereby assume joint responsibility for the form and composition of each and all of the contents of this Agreement, and they further agree that this instrument shall be interpreted as though each of the Parties participated equally in the composition of this instrument, and each and every part thereof.

9.7. Severability. In the event that any covenant, condition or other provision herein contained is held to be invalid, void or illegal by any court of competent jurisdiction, the same shall be deemed severable from the remainder of this Agreement and shall in no way affect, impair or invalidate any other covenant, condition or provision herein contained. If such condition, covenant or other provision shall be deemed invalid due to its scope or breadth, such covenant, condition or other provision shall be deemed valid to the extent of the scope or breadth permitted by law.

9.8. Counterparts. This Agreement may be executed in several counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute and be one and the same instrument.

9.9. Governing Law. The rights and duties of the Parties and the construction of this Agreement shall be governed by the laws of the State of California.

9.10. Benefit. This Agreement is not intended to confer upon any Person other than Manager, the Affiliates and Health System any rights, obligations or remedies hereunder.

9.11. Headings; Interpretation. The descriptive heading of the articles and sections of this Agreement are inserted for convenience only, do not constitute a part of this Agreement and shall not control or affect in any way the meaning or interpretation of this Agreement. Whenever the words "include," "includes" or "including" are used in this Agreement, they shall be deemed to be followed by the words "without limitation." "Person" means any natural person, general or limited partnership, corporation, limited liability company, firm, association, trust or other legal entity or organization, including a government or political subdivision or an agency or instrumentality thereof.

9.12. Access to Books. As an independent contractor of Health System, Manager shall, in accordance with 42 U.S.C. §1395(v)(1)(I) and 42. C.F.R. Part 420, Subpart D § 420.300 et seq., until the expiration of four (4) years after the furnishing of Medicare reimbursable services pursuant to this Agreement, upon proper written request, allow the Comptroller General of the United States, the Secretary of Health and Human Services, and their duly authorized representatives access to this Agreement and to Manager's books, documents and records necessary to certify the nature and extent of costs of Medicare reimbursable services provided under this Agreement. In accordance with such laws and regulations, if Medicare reimbursable services provided by Manager under this Agreement are carried out by means of a subcontract with an organization related to Manager, and such related organization provides the services at a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, then the subcontract between Manager and the related organization shall contain a clause comparable to the clause specified in the preceding sentence.

9.13. Referrals. The Parties acknowledge that none of the benefits granted Manager is conditioned on any requirement that Manager or any of its owners or affiliates make referrals to, be in a position to make or influence referrals to, or otherwise generate business for any Affiliate or the Health System.

9.14. Confidentiality of Manager Information. Each Party recognizes and acknowledges that, by virtue of entering into this Agreement and carrying out the transactions and performing the obligations contemplated herein, each Party and its affiliates, may have access to certain confidential information of the other Party, including, to the extent reasonably protected as confidential and not disclosed to the public or in an unrestricted manner, the policies and procedures and operating manuals, costs and financial information, methods and systems of care delivery, outcome and quality measures, and other information and materials. Except as set forth below, neither Party, nor its affiliates, delegates or contractors, will at any time, either during or subsequent to the Term of this Agreement, disclose to others, use, copy or permit to be copied, without the other Party's express prior written consent any such confidential or proprietary information of the other Party. Notwithstanding the foregoing, neither party will be restricted in any manner from disclosure or use of (i) any information or materials that it independently develops without the use of or reliance upon the confidential information of the other Party, (ii) any information or materials that becomes publicly accessible or available without the breach of this Section 9.14, (iii) any information or material lawfully acquired from a third party not under a duty not to disclose or provide such material. In addition, neither Party will be restricted from (i) disclosing or using confidential information of the other Party to the extent required by law, or (ii) disclosing confidential information of the other Party to its

attorneys, accountants, and other professional service providers in connection with the rendering of their professional services.

9.15. Confidentiality of Terms of This Agreement. Except for disclosure to their legal counsel, accountants or financial advisors, each Party hereto warrants and covenants to each other Party that neither it nor its officers, employees, or agents shall disclose the terms of this Agreement to any Person who is not a Party, unless disclosure thereof is required by law or in connection with the California Attorney General's approval and monitoring of certain transactions between Health System, BlueMountain Capital Management, LLC, and Manager pursuant to Corporations Code section 5914 *et seq.*, or by any other Person legally entitled to review this Agreement as of the Effective Date, or otherwise authorized by this Agreement or consented to by each other Party. Unauthorized disclosure of the terms of this Agreement shall be a material breach of this Agreement.

9.16. Execution of Agreement. This Agreement shall not become effective or in force until all of the required signatories below have executed this Agreement.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK;
SIGNATURE PAGE TO FOLLOW

IN WITNESS WHEREOF, the parties hereto have executed this Health System Management Agreement on the day and year first above written.

MANAGER:
INTEGRITY HEALTHCARE, LLC
By: BlueMountain Capital Management, LLC, its manager

By: _____
Name: Richard Horne
Title: Associate General Counsel, Tax

HEALTH SYSTEM:

VERITY HEALTH SYSTEM OF CALIFORNIA, INC.
For Itself and as Attorney in Fact for the Health System's Affiliates solely for purposes of Sections 6.1 and 6.2

By: _____
Name: Robert Issai
Title: President and Chief Executive Officer

ATTACHMENT 1
HOSPITALS

O'Connor Hospital

St. Vincent Medical Center

St. Francis Medical Center

Saint Louise Regional Hospital

Seton Medical Center and the skilled nursing home and emergency department known as Seton Medical Center – Coastside, a division of Seton Medical Center

EXHIBIT A
SYSTEM AUTHORITY MATRIX

(SEE ATTACHED)

SYSTEM AUTHORITY MATRIX

VERITY HEALTH SYSTEM OF CALIFORNIA, INC. AND ITS AFFILIATES

Dated: December 14, 2015

Attached is a matrix which lists a number of important actions that might be taken by an entity affiliated with Verity Health System of California, Inc. and the corresponding approvals it must obtain before proceeding with such action. This matrix is intended not only to inform each entity of the need to obtain approval or give notification before acting, but also to clearly set forth the rights that are reserved to or held by certain governing entities within the organization.

The attached matrix is not intended to be an exclusive listing of the various powers reserved to System and its affiliated entities; additional powers may exist by operation of law or by virtue of policies currently existing or which may in the future be added or developed by Verity. Moreover, nothing in the attached matrix is intended to limit the right or ability of any corporation or entity, including Verity and Manager, to initiate certain corporate or operational actions on behalf of any of its subsidiaries or their subsidiaries. Certain decisions and authorities set forth in the attached matrix may require consultation with and recommendations by the Manager, as part of the rights Manager may possess under the Management Agreement.

Many of the terms that appear in the attached tables have meanings that are specific to the matrix. These terms are defined below:

1. Affiliate means a corporation or other legal entity of which Verity is the sole voting shareholder, owner, or corporate member. For the avoidance of doubt, all of the hospitals and Verity Medical Foundation are Affiliates.

2. Affiliate Board means the board of directors, board of trustees, or other governing body charged with managing the activities and affairs of an Affiliate.

3. Affiliate CEO means the Chief Executive Officer of each of the Affiliates.

4. Management Agreement means that certain Health System Management Agreement dated as of even date herewith and entered into in connection with the closing of that certain System Restructuring and Support Agreement, dated July 17, 2015,

made by and among Daughters of Charity Ministry Services Corporation, Daughters of Charity Health System (now known as Verity), Manager, and certain funds managed by BlueMountain Capital Management, LLC.

5. Manager means Integrity Healthcare, LLC, a Delaware limited liability company, the manager of Verity Healthcare System pursuant to the Management Agreement.

6. Verity means Verity Health System of California, Inc., a California nonprofit corporation (formerly known as Daughters of Charity Health System) that is the "parent corporation" of those hospital, healthcare, and other entities that make up the Verity Healthcare System.

7. Verity Board means the Board of Directors of Verity Health System of California, Inc.

8. Verity CEO/President means the individual duly elected and acting as the Chief Executive Officer and President of Verity Health System of California, Inc. For as long as the Management Agreement is in effect, the Verity CEO/President shall be an employee of Manager and shall report to the Manager.

9. Verity Healthcare System means, collectively Verity, the Affiliates, and all direct and indirect subsidiaries of Verity and the Affiliates, and all other entities affiliated with Verity.

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
I. Mission, Values, Expectation				
Adopt, approve, assure compliance with, change and interpret statements of mission, role, or purpose of the Verity and Affiliates			Recommend	Approve
Adopt, approve, assure compliance with, change or interpret statements of Verity's core values and expectations				Approve
II. Governing Documents and Formation of Entities				
Adopt, approve, amend, restate Articles and Bylaws of Verity				Approve
Adopt, approve, amend, restate Articles and Bylaws of the Affiliates	Recommend	Approve	Recommend	Approve
Adopt, approve, amend, restate Articles and Bylaws or other organizational documents of subsidiaries of Affiliates	Recommend	Approve		Approve
Approve the formation of new legal entities by Verity			Recommend	Approve
Approve the formation of new legal entities by	Recommend	Recommend	Recommend	Approve

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
the Affiliates				
III. Merger, Consolidation, Dissolution, Divestiture				
Approve the merger, dissolution, consolidation, divestiture, dissolution, closure, change in corporate membership or corporate reorganization or sale of all or substantially all of the assets of Verity			Recommend	Approve
Approve the merger, dissolution, consolidation, divestiture, dissolution, closure, change in corporate membership or corporate reorganization or sale of all or substantially all of the assets of any of the Affiliates or their subsidiaries		Recommend	Recommend	Approve
IV. Appointments/Removals				
Appoint or remove members of the Board of Directors of Verity				Appoint and Remove
Appoint or remove Chair of System Board				Appoint and Remove
Appoint or remove board members of Affiliates a. Verity Directors				Appoint and Remove

Case: 19-10226-RBK Doc#: 1-6 Filed: 01/29/19 Entered: 01/29/19 10:56:50 Desc
Desc Exhibit 6 (Integrity Management Agreement) Page 39 of 67

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	**Affiliate Board**	**Verity CEO/President**	**Verity Board**
b. At-large Directors	Consult	Consult	Consult	Appoint and Remove
Appoint or remove Affiliate Board Chairs				Appoint and Remove
Appoint or remove Verity CEO/President				Appoint and Remove
Appoint or Remove CEO of Affiliate		Consult on appointment and removal	Recommend and Consult on appointment and removal	Appoint and Remove
Appoint or Remove CFO, Chief Operating Officer, Director of Clinical and Medical Affairs of Verity			Appoint and Remove	
Appoint or Remove CFO and other corporate and executive officers of Affiliate	Appoint and Remove with concurrence of Verity CFO and consultation of Affiliate Board	Consult on appointment and removal		
Appoint or Remove System General Counsel			Recommend	Appoint and Remove
V. Evaluation of Officers				
Evaluate performance of Verity Board Chair				Evaluate/Approve

Case: 19-10384 Doc: 2 Filed: 05/29/19 Entered: 05/29/19 08:56:50 Desc
Case 19-10384-BFK Doc 2-6 Filed 05/29/19 Entered 05/29/19 08:56:50 Desc
Desc Exhibit 6 (Integrity Management Agreement) Page 40 of 67

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
Evaluate performance of Affiliate Board Chairs		Consult	Consult	Evaluate/Approve
Evaluate performance of Verity CEO/President			Consult	Evaluate/Approve
Establish annual performance objectives and determine compensation of Verity CEO/President			Consult	Approve
Evaluate performance of Affiliate CEOs and other executive officers of Affiliates		Consult	Approve, acting with Affiliate Board Chair	
Establish annual performance objectives and determine compensation of Affiliate Presidents/CEOs and other executive officers of Affiliates	Consult	Consult	Approve	
Establish compensation and benefit programs for employees of Verity and the Affiliates			Recommend	Establish, evaluate, and approve
VI. Debt, Strategic & Financial Plans and Capital and Operating Budgets				

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
Establish overall debt limit and centralized debt management program covering Verity, the Affiliates, and all subsidiaries of the Affiliates			Recommend	Approve
Approve incurrence or guarantee of debt by Affiliates in excess of limits permitted by this Matrix	Recommend	Recommend	Recommend	Approve
Approve incurrence of debt under Master Trust Indenture			Recommend	Approve
Establish criteria for financial and strategic plans for Verity			Recommend	Approve
Establish criteria for financial and strategic plans for the Affiliates			Recommend	Approve
Approve strategic plan for DCHS			Recommend	Approve
Approve Affiliate strategic plans	Recommend	Recommend	Recommend	Approve
VII. System-Wide Policies				

Case: 18-10601 Doc: 254-6 Filed: 05/29/18 Entered: 05/29/18 10:56:50 Desc
Desc Exhibit 6 (Integrity Management Agreement) Page 42 of 67

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	**Affiliate Board**	**Verity CEO/President**	**Verity Board**
Approve and amend System policies and procedures			Recommend	Approve
VIII. Audit				
Approve/Remove external auditor for System			Recommend	Approve
IX. Capital Expenditures, Lease Obligations as Lessee and Incurrence of Debt by Affiliates and their Subsidiaries				
Establish internal audit program for System and Affiliates			Recommend	Approve
Budgeted amounts: over $3,000,000	Recommend	Recommend	Recommend	Approve
$1,000,000 to $3,000,000	Recommend	Recommend	Approve	
$500,000 to $1,000,000	Recommend	Approve		
Up to $500,000	Approve			
Unbudgeted amounts: up to $50,000	Approve	Approve		
$50,000 up to $100,000	Recommend	Recommend	Approve	
$100,000 up to $1,000,000	Recommend	Recommend	Recommend	Approve

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
Over $1,000,000	Recommend	Recommend	Recommend	Approve
X. Leases as Lessor Conveying Property in the Normal Course of Business				
Initial Leases	Recommend	Recommend	Recommend	Approve
Renewal of term of up to three years, or aggregate rent of less than $250,000	Approve			
Renewal term of more than three years, but less than five years, or aggregate rent of more than $250,000 but less than $500,000	Recommend	Approve		
Renewal term of five or more years, or aggregate rent equal to or greater than $500,000	Recommend	Recommend	Approve	Approve

Case: 19-10412 Doc: 256-6 Filed: 05/29/19 Entered: 05/29/19 08:56:50 Desc
Case 19-10412-BLS Doc 256-6 Filed 05/29/19 Page 44 of 67
Desc Exhibit 6 (Integrity Management Agreement)

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
XI. Physician Contracts[1]				
Physician recruitment loan agreements. Note: all physician recruitment loan agreements must be supported by a favorable legal opinion, with particular attention to Medicare/Medicaid anti-fraud and abuse, Stark, and private inurement/private benefit	Recommend	Recommend	Recommend	Approve
All other physician contracts, agreements, incentives, lines of credit or loans Note: All physician contracts described by this section must be supported by a favorable legal opinion, with particular attention to Medicare/Medicaid anti-fraud & abuse, Stark, and private inurement/private benefit	Recommend	Approve		

[1] With Verity CEO/President approval, Affiliate CEO may execute otherwise compliant physician agreements and leases when unforeseen need for physician arises and Chief Restructuring Officer or legal counsel of Verity or the Verity Healthcare System advises that a signed agreement is required for legal compliance. Any such agreement shall be reported to the Board of Directors of the Affiliate that is party to such agreement at its next meeting.

Case: 19-10226-RBB Doc#:2 Filed: 05/29/19 Entered: 05/29/19 08:56:50 Desc
Desc Exhibit 6 (Integrity Management Agreement) Page 45 of 67

DECISIONS/AUTHORITY	REQUIRED RECOMMENDATION OR APPROVAL			
	Affiliate CEO	Affiliate Board	Verity CEO/President	Verity Board
XII. Routine Contracts for Supplies and Non-Physician Services				
Contract new/renewal for two years or less and:				
Cumulative value up to $1,000,000	Approve			
Cumulative value above $1,000,000	Recommend	Recommend	Approve	
Contract new/renewal for more than two years and/or:				
Cumulative value up to $2,000,000	Recommend	Approve	Approve	
Cumulative value above $2,000,000	Recommend	Recommend	Approve	
XIII. Construction Contracts (as part of approved budget or capital projects)				
Cumulative Contract Value of:				
Over $3,000,000	Recommend	Recommend	Recommend	Approve
$1,000,000 to $3,000,000	Recommend	Recommend	Approve	
$500,000 to $1,000,000	Recommend	Recommend	Approve	
Up to $500,000	Recommend	Approve		

Case: 19-10156-RBB Doc#:2 Filed: 05/29/19 Entered: 05/29/19 10:56:50 Desc Exhibit 6 (Integrity Management Agreement) Page 46 of 67

XIV. Sale of Property of Capital Assets in the Normal Course of Business				
Book value of less than $50,000 Book value between $50,000 and $250,000 Book value between $250,000 and $1,000,000 Book value of $1,000,000 and above	Approve Recommend Recommend Recommend	Approve Recommend Recommend	Approve Recommend	Approve
XV. New Bank Accounts and Investment Accounts				
Affiliate and its subsidiaries	Recommend	Recommend	Approve	
System and its non-hospital Affiliates and Verity Medical Foundation			Recommend	Approve
XVI. Settlement of Claims				
Sexual harassment and sexual abuse claim settlement approval Up to $250,000 Over $250,000	Recommend Recommend	Recommend Recommend	Approve Recommend	Approve
All other claims, no matter the nature or size			Recommend	Approve

Case: 19-10412 Doc# 2954-6 Filed: 05/29/20 Entered: 05/29/20 07:03:50 Desc
Case: 19-10412 Doc# 2954-6 Filed: 05/29/20 Entered: 05/29/20 07:03:50 Desc
Desc Exhibit 6 (Integrity Management Agreement) Page 47 of 67

EXHIBIT B
BUSINESS ASSOCIATE ADDENDUM
(SEE ATTACHED)

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (the "**Addendum**") supplements and is made a part of the July 17, 2015 Transitional Consulting Services Agreement by and between the Covered Entities listed on Attachment I (each a "**Covered Entity**" or "**CE**") and Integrity Healthcare, LLC, a Delaware limited liability company ("**Business Associate**" or "**BA**"). This Addendum is effective as of the date of the Contract (the "**Addendum Effective Date**").

A. Immediately upon expiration of the Transitional Consulting Services Agreement, the Covered Entities and the Business Associate intend to enter into a Health System Management Agreement under which the Business Associate will continue to provide management and other services on behalf of the Covered Entities. The Transitional Consulting Services Agreement and the Health System Management Agreement are each a "**Contract**" and are collectively the "**Contracts.**"

B. Pursuant to the terms of the Contracts and in connection with those services, CE may need to disclose to BA, or BA may need to create on CE's behalf, certain Protected Health Information ("**PHI**") (defined below).

C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Contract in compliance with the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act (the "**HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "**HIPAA Regulations**") and other applicable laws.

D. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to BA's receipt or creation of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("**C.F.R.**") and contained in this Addendum.

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. Definitions

a. **Breach** shall have the meaning given to such term under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

b. **Business Associate** shall have the meaning given to such term under 42 U.S.C. § 17938 and 45 C.F.R. § 160.103.

c. **California Confidentiality Laws** shall mean the laws of the State of California governing the confidentiality of PHI, including, but not limited to, the California Confidentiality of Medical Information Act (Cal. Civil Code § 56 *et seq.*), the patient access law (Cal. Health & Safety Code §

123100 *et seq.*), the HIV test result confidentiality law (Cal. Health & Safety Code § 120975 *et seq.*), the Lanterman-Petris-Short Act (Cal. Wel. & Inst. Code § 5328 *et seq.*), the medical identity theft law (Cal. Civil Code § 1798.82), and the improper access notification law (Cal. Health & Safety Code § 1280.15).

d. **Covered Entity** shall have the meaning given to such term under 45 C.F.R. § 160.103.

e. **Data Aggregation** shall have the meaning given to such term under 45 C.F.R. § 164.501.

f. **Designated Record Set** shall have the meaning given to such term 45 C.F.R. § 164.501.

g. **Electronic Protected Health Information or EPHI** means Protected Health Information that is maintained in or transmitted by electronic media.

h. **Electronic Health Record** shall have the meaning given to such term under 42 U.S.C. § 17921(5).

i. **Health Care Operations** shall have the meaning given to such term under 45 C.F.R. § 164.501.

j. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

k. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of DCHS to an individual; or the past, present or future payment for the provision of DCHS to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under 45 C.F.R. § 160.103. PHI includes EPHI.

l. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

m. **Security Incident** shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

n. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

o. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services (the "**Secretary**").

2. **Obligations of Business Associate**

a. **General Requirements; Permitted Uses and Disclosures.** BA agrees to comply with all applicable provisions in HIPAA, the HITECH Act, the HIPAA Regulations, and the California Confidentiality Laws. BA shall not use or disclose Protected Information except for the purpose of performing BA's obligations under the Contract and as permitted under this Addendum. BA may use Protected Information, if necessary (i) for the proper management and administration of BA, (ii) to carry out the legal responsibilities of BA, or (iii) for Data Aggregation purposes for the Health Care Operations of CE.

b. **Prohibited Uses and Disclosures.** BA agrees to comply with the prohibition of sale of PHI without authorization under 45 C.F.R. § 164.502 unless an exception under 45 C.F.R. § 164.508 applies.

c. **Appropriate Safeguards.** BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by Addendum. BA shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI as required by the Security Rule. To the extent that BA creates, maintains, receives or transmits EPHI on behalf of CE, BA shall implement the safeguards required by this Section 2(c) with respect to EPHI.

d. **Mitigation.** BA shall mitigate, to the extent practicable, any harmful effect that is known to BA of a use or disclosure of PHI in violation of this Addendum.

e. **Reporting of Unauthorized Uses or Disclosures and Securities Incidents.** BA shall report to CE in writing any access, use or disclosure of Protected Information not provided for or permitted by this Addendum, the Privacy Rule, the California Confidentiality Laws or other applicable federal or state law, and any Security Incidents, of which BA becomes aware. BA shall notify CE according to this Section 2(e) promptly, and in no case longer than five (5) calendar days, after BA becomes aware of such unauthorized use, disclosure or Security Incident. Notwithstanding the foregoing, Business Associate and Covered Entity acknowledge the ongoing existence and occurrence of attempted but ineffective Security Incidents that are trivial in nature, such as pings and other broadcast

service attacks, and Covered Entity acknowledges and agrees that no additional notification to Covered Entity of such ineffective Security Incidents is required, as long as no such incident results in unauthorized access, Use or Disclosure of PHI.

f. **Reporting of Breach of Unsecured Protected Information.** BA shall promptly, and in no case longer than five (5) calendar days, after discovery of a Breach under HIPAA or breach under California Confidentiality Laws, report to CE such Breach/breach, consistent with HIPAA, the HIPAA Regulations, and the California Confidentiality Laws. BA also must, without unreasonable delay, identify each individual whose Unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of the Breach/breach, and provide such information to CE as needed in order to meet the data breach notification requirements under the HIPAA Regulations and the California Confidentiality Laws. The Breach/breach shall be considered "discovered" when the BA knew or reasonably should have known when the Breach occurred.. BA agrees to fully cooperate, coordinate with and assist CE in gathering the information necessary to notify the affected individuals. BA agrees to cooperate with CE to ensure that all such Breach/breach notices are sent without unreasonable delay, and in no case more than fifteen (15) business days from the discovery of the Breach/breach and in accordance with applicable state laws. BA agrees that it shall be solely responsible for all reasonable costs and expenses incurred by both CE and BA as a result of the Breach/breach, including costs associated with mitigation, preparation and delivery of the notices, to the extent that the Breach/breach is caused by a violation of this Addendum by BA,.

g. **Business Associate's Subcontractors and Agents.** BA shall ensure that any agents or subcontractors to whom it provides Protected Information agree in writing to the substantially the same restrictions and conditions that apply to BA with respect to such PHI. If BA knows of a pattern of activity or practice of an agents or subcontractor that constitutes a violation of the agent's or subcontractor's obligations to BA, then BA shall take reasonable steps to end the violation, and if such steps are unsuccessful, BA must terminate the arrangement if feasible.

h. **Access to and Amendment of Protected Information**. To the extent that BA or its agents or subcontractors maintains a Designated Record Set on behalf of CE and to enable CE to fulfill its obligations under the Privacy Rule, BA shall make Protected Information in Designated Record Sets that are maintained by Subcontractor or its agents or subcontractors available to CE for inspection, copying or amendment within ten (10) calendar days of a request by CE. If an Individual requests inspection, copying or amendment of Protected Information directly from BA or its agents or

subcontractors, BA shall notify CE in writing within five (5) business days of receipt of the request.

i. **Accounting Rights**. BA shall implement a process for recording certain Disclosures of Protected Information by BA ("**Accounting Information**") in order to enable CE to comply timely with its obligations under the Privacy Rule including, but not limited to, 45 C.F.R. § 164.528. At a minimum, this Accounting Information shall include, for each such Disclosure, recordation of (a) the date of Disclosure; (b) the name and address of the recipient of the Protected Information; (c) a brief description of the Protection Information disclosed; and (d) a brief statement of the purpose for the Disclosure that reasonably informs the Individual of the basis for the Disclosure. Within thirty (30) calendar days of notice from CE of a request for an accounting of Disclosures of PHI, BA shall make available to CE this Accounting Information. If an Individual requests an accounting directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) business days of the request.

j. **Governmental Access to Records**. BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining CE's and/or BA's compliance with HIPAA, the HIPAA Regulations and the HITECH Act. BA shall notify CE regarding any Protected Information that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary and, upon CE's request and at its expense, shall provide CE with a duplicate copy of such Protected Information, unless prohibited by the Secretary.

k. **Minimum Necessary**. BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure.

l. **Requests for Restrictions.** BA agrees to comply with requests for restrictions on use or disclosure of Protected Information that CE has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect BA's use or disclosure of such Protected Information and the CE provides written notice of such restriction five (5) business days prior to any requested use or disclosure.

m. **Direct Access to CE's Electronic Systems.** If BA or its employees/agents are granted direct access to CE's electronic systems, then BA will ensure that each of its employees and agents has access only to what is required for each employee/agent to perform the specific duties assigned by BA to that individual employee/agent pursuant to the Contract with CE. Furthermore, BA will provide immediate notice to the person designated by CE by email when its employees/agents are terminated or

change roles or otherwise no longer have a need for access, BA will routinely monitor the list of employees/agents with access, BA will educate its employees/agents that sharing of log-in information among its employees/agents is prohibited, and BA will provide CE with a list of its employees/agents with access to CE's electronic systems upon request by CE.

n. **Compliance with CE's Obligations.** To the extent that BA carries out CE's obligations under HIPAA, the HIPAA Regulations or the California Confidentiality Laws, BA shall comply with all of the requirements of HIPAA, the HIPAA Regulations and the California Confidentiality Laws in the performance of such obligations.

3. **Term and Termination.**

a. **Term.** The term of this Addendum shall be coterminous with the Health System Management Agreement, unless the parties do not enter into such agreement, in which case this Addendum shall be coterminous with the Transition Services Agreement. However, BA shall have a continuing obligation to safeguard the confidentiality of Protected Information received from CE after the termination of the Contracts.

b. **Termination for Cause.** Upon CE's knowledge of a material breach by BA of any provision of this Addendum, CE may either (1) terminate this Addendum upon thirty (30) calendar days prior written notice to BA in the event BA does not cure such breach to the reasonable satisfaction of CE within such thirty (30) calendar day period; or (2) terminate this Addendum immediately and, to the extent BA cannot perform the services without access to Protected Information, the relevant Contract (or portions thereof) related to such breach.

c. **Effect of Termination.** Upon termination of this Addendum for any reason, BA shall return or destroy all Protected Information that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. Upon CE's request, BA shall certify in writing that such return or destruction has occurred. If BA determines that return or destruction is not feasible, BA shall explain to CE in writing the conditions make the return or destruction of such Protected Information unfeasible. In such an event, BA shall retain the Protected Information subject to all of the protections of this Addendum, and shall limit further Uses or Disclosures to those purposes that make the return or destruction of the Protected Information unfeasible, for so long as BA maintains such Protected Information. In any event, BA also shall maintain a record of disclosures (pursuant to Section 3(i) of this Addendum) for a period of six (6) years and make it available to CE upon request in an electronic format so that CE may meet its disclosure accounting obligations under 45 C.F.R. § 164.528.

4. **Indemnifications; Limitation of Liability**. To the extent permitted by law, each Party shall indemnify, defend and hold harmless the other Party from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of said Party in connection with Party's representations, duties and obligations under this Addendum.

5. **Amendment to Comply with Law**. Because state and federal laws relating to data security and privacy are rapidly evolving, amendment of the Addendum may be required to provide for procedures to ensure compliance with such developments. BA and CE shall take such action as is necessary to implement the standards and requirements of pursuant to HIPAA, the HIPAA Regulations, the HITECH Act, the California Confidentiality Laws and any other applicable federal or state laws. This Addendum may not be modified, and no provision hereof shall be waived or amended, except in a writing duly signed and agreed to by BA and CE.

6. **No Third-Party Beneficiaries**. Nothing express or implied in the Contract or Addendum is intended to confer, nor shall anything herein confer upon any Person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

7. **Interpretation**. This Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations, the HITECH Act and the California Confidentiality Laws. The Parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, the HITECH Act and the California Confidentiality Laws.

8. **Regulatory References**. A reference in this Addendum to a section of regulations means the section as in effect or as amended, and for which compliance is required.

9. **Identity Theft Program Compliance**. To the extent that CE is required to comply with the final rule entitled "Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003," as promulgated and enforced by the Federal Trade Commission (16 C.F.R. Part 681) ("**Red Flags Rule**"), and to the extent that BA is performing an activity in connection with one or more "covered accounts," as that term is defined in the Red Flags Rule, pursuant to the Contract, BA shall establish and comply with its own reasonable policies and procedures under the applicable laws.

10. **Assistance in Litigation and Administrative Proceedings**. BA shall make itself, and any employees or agents, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA, the HIPAA Regulations, or the HITECH Act that is caused by BA, except where BA or its subcontractor, employee or agent is a named adverse party.

11. **Subpoenas**. In the event that BA receives a subpoena or similar notice or request from any judicial, administrative or other party arising out of or in connection with this Addendum, including, but not limited to, any unauthorized use of disclosure of PHI, BA shall promptly forward a copy of such subpoena, notice or request to Covered Entity to afford Covered Entity

the opportunity to exercise any rights it may have under law, provided that BA is not prohibited by law from providing such notice.

12. Governing Law. This Addendum shall be governed by and construed in accordance with the laws of the State of California to the extent that the provisions of HIPAA, the HIPAA Regulations or the HITECH Act do not preempt the laws of the State of California.

13. Survival. The respective rights and obligations of BA under Section 2 (Obligations of Business Associate), Section 3(c) (Effect of Termination), Section 10 (Assistance in Litigation and Administrative Proceedings), Section 11 (Subpoenas), Section 12 (Governing Law), and this Section 13 (Survival) will survive the termination of this Addendum.

[Remainder of Page Left Blank Intentionally].

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

BUSINESS ASSOCIATE:

INTEGRITY HEALTHCARE, LLC

By: [signature]

Name: Richard Horne

Title: Associate General Counsel, Tax

Date: 9-11-15

[SIGNATURE PAGE TO BUSINESS ASSOCIATE ADDENDUM]

COVERED ENTITY:

O'CONNOR HOSPITAL

By: Sister Margaret Keaveney
Print: Sr. Margaret Keaveney
By: President and Chief Executive Officer
Date: 9/14/15

COVERTED ENTITY:

SAINT LOUISE REGIONAL HOSPITAL

By: Sister Margaret Keaveney SC
Print: Sr. Margaret Keaveney
Title: President and Chief Executive Officer
Date: 9/14/15

COVERED ENTITY:

SETON MEDICAL CENTER

By: John Ferrelli

Print: John Ferrelli

Title: Chief Executive Officer

Date: 9-11-15

COVERED ENTITY:

ST. VINCENT MEDICAL CENTER

By: Margaret C Fickes
Print: Margaret Catherine Fickes
Title: President and Chief Executive Officer
Date: 9/14/18

COVERED ENTITY:

ST. VINCENT DIALYSIS CENTER, INC.

By: Margaret C Fickes
Print: Margaret Catherine Fickes
Title: President and Chief Executive Officer
Date: 9/14/18

COVERED ENTITY:

ST. FRANCIS MEDICAL CENTER

By: _____

Print: Gerald T. Kozai

Title: President and Chief Executive Officer

Date: 9/14/2018

COVERED ENTITY:

DCHS MEDICAL FOUNDATION

By: _____
Print: Steve Balalian
Title: President and Chief Executive Officer
Date: 9/14/15

DAUGHTERS OF CHARITY HEALTH SYSTEM

By:_____
Print: Robert Issai
Title: President and Chief Executive Officer
Date: September 11, 2015

CARITAS BUSINESS SERVICES

By:_____
Print: Richard Hutsell
Title: Secretary
Date: _____

DAUGHTERS OF CHARITY HEALTH SYSTEM

By:_____
Print: Robert Issai
Title: President and Chief Executive Officer
Date: _____

CARITAS BUSINESS SERVICES

By:_____
Print: Richard Hutsell
Title: Secretary
Date: 9-17-2015

ATTACHMENT I

COVERED ENTITIES:

Seton Medical Center
O'Connor Hospital
Saint Louise Regional Hospital
St. Francis Medical Center
St. Vincent Medical Center
St. Vincent Dialysis Center
DCHS Medical Foundation

Daughters of Charity Health System*
Caritas Business Services*

*As parties to each of the Contracts, these entities are also parties to the Addendum. These entities are not Covered Entities but rather are HIPAA Business Associates within the meaning of 45 C.F.R. § 160.103 of the Covered Entities. There is currently a Business Associate Agreement in place between each such entity and each of the Covered Entities.