St. Andrews Hospital

Breach of a Community's Trust

ST. ANDREWS HOSPITAL: BREACH OF A COMMUNITY'S TRUST

BACKGROUND

A. Current Status

St. Andrews Hospital ("St. Andrews") is a 25-bed critical access hospital ("CAH") and Section 501(c)(3) public benefit corporation located in Boothbay Harbor, Maine. St. Andrews serves the greater Boothbay region, which includes the towns of Boothbay, Boothbay Harbor, East Boothbay, Edgecomb, Southport, and Trevett.

St. Andrews offers a 24/7 Emergency Department ("ED"), inpatient care, physical and occupational therapy, laboratory services, imaging, outpatient clinical services, and other services. Notably, St. Andrews is the only hospital north of the Carolinas accessible by land, sea, and air, which is vital in a region where much of the population either lives on peninsulas not quickly reachable by land or on nearby islands. St. Andrews has been recognized recently for its quality of care. In 2009, the hospital was recognized by Anthem for achieving a perfect score of 112 in Anthem's hospital incentive program. This was the highest score in the northeast, and much higher than the average of 87.67 points.[1]

B. History of St. Andrews Hospital

St. Andrews has been a cornerstone and critical service provider for the Boothbay Region since 1908, when Dr. George Gregory opened the Gregory Sanatorium in Boothbay Harbor as a private facility. Dr. Gregory renamed his facility St. Andrews Hospital five years later. He served as physician and administrator until his death in 1946, when he handed the reins to his son, Dr. Phillip Gregory. The younger Dr. Gregory continued to serve as physician and administrator of St. Andrews for 20 more years. In 1955, the hospital became a nonprofit organization.[2]

Since the 1950s, relying largely on donated funds, St. Andrews has undergone significant expansion and renovation. In 1959, a new 30-bed facility was built.[3] In 1980, an ED was added, and in 1987 a new acute care wing was opened with 22 hospital beds with $2.3 million in local support.[4] From 1994 through 2000, St. Andrews expanded its outpatient clinic, opened a school health center, and opened St. Andrews Village, a hospital-sponsored full service retirement community nearby to the hospital campus.[5] In 2002, supported by a $6.5 million capital campaign, another major renovation was undertaken to benefit surgery, the emergency department, the laboratory and imaging departments, and electrical and mechanical systems.[6]

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[1] *See* Lincoln County Healthcare Annual Report 2011 at 4, available at http://www.mainehealth.org/workfiles/miles_media/LCH%20Annual%20Rep%202011.pdf).

[2] *See* Sue Mello, "A community waits," *Boothbay Register*, July 30, 2012, available at http://www.boothbayregister.com/article/community-waits/1407.

[3] *Id.* ("In 1959, a new 30-bed facility was built. Half of the $910,000 cost was raised locally.").

[4] *Id.*

[5] *Id.*

[6] *Id.*

Additionally, as an organization exempt from local property taxes, St. Andrews has saved $758,828.57 in taxes during 2003-2012.[7] The St. Andrews Auxiliary has provided over one million dollars in support to St. Andrews since the Auxiliary's founding in 1952. A list of donations made by the Auxiliary to St. Andrews is attached as Exhibit 1.

In 1997, St. Andrews became the first hospital to enter into an affiliation agreement with MaineHealth, the Portland-based corporate parent of Maine Medical Center. A copy of the Definitive Agreement that consummated the affiliation, and an amendment thereto, is attached hereto as Exhibit 2. This affiliation made St. Andrews a wholly-owned subsidiary of MaineHealth, which gave MaineHealth exclusive authority to make key decisions for St. Andrews, such as electing St. Andrews' board, budget approval, and termination of programs and services.[8] In 2007, MaineHealth created Lincoln County Healthcare ("LCH") to serve as the parent corporation for St. Andrews and Miles Memorial Hospital ("Miles"). MaineHealth is the sole corporate member of LCH, and LCH's board is elected by MaineHealth's board.[9]

LCH's powers over St. Andrews mirror those that MaineHealth had over St. Andrews, including electing St. Andrews' board. Under this new parent corporation, the hospitals consolidated their boards of trustees, management teams, and medical staffs. However – and importantly – Miles' management team was largely placed in control of LCH.

This completely changed the governance dynamics of St. Andrews relative to MaineHealth and resulted, to a large extent, in disenfranchising the former St. Andrews Board. This governance structure was not contemplated when St. Andrews initially agreed to join MaineHealth in 1997.

The result is one Board and one management team. Instead of the traditional Board that was representative of the Boothbay region and served its interests so well for many years, there is now a single Chief Executive Officer and a single group of individuals, appointed by MaineHealth, who wear three hats: they serve simultaneously as the Board of LCH, the Board of Miles and the Board of St. Andrews. While some Board members are representative of the Boothbay region, they are in the minority on the new Board. Although this governance structure can work well in most day-to-day situations, a potential, built in conflict arises when the interests of one community differ from that of the other community served, for example when the interests of the Miles differ from those of St. Andrews - and that appears to be the situation here, and what promoted a decision that favored the Miles community over the needs of the Boothbay community.

Since LCH was formed, it has gradually eliminated services at St. Andrews. In 2010 LCH scaled back St. Andrews' surgical and acute inpatient programs, and since Spring 2012 St. Andrews no longer offers outpatient surgery. The Miles-led Board has shifted these services to Miles. These decisions by LCH (and MaineHealth) have resulted in a substantial loss in revenue to St. Andrews and ultimately endanger St. Andrews' viability, both financially and clinically, as a free-standing hospital.

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[7] *See* Exhibit 3 (Table adapted from information provided by Jim Chaousis, Boothbay Town Manager)..

[8] Additional powers of MaineHealth over St. Andrews are also found in the 1997 amendment to St. Andrews' articles of incorporation, a copy of which is attached as Exhibit 4.

[9] A copy of LCH's articles of incorporation is attached as Exhibit 5.

However, the patient need for health care services in the Boothbay peninsula remains unchanged. If anything, the patient need for health care services has increased. By way of example, between 2010 and 2012, St. Andrews ED experienced more than a 50% increase in ED visits.

The year-round population in the Boothbay peninsula region remains largely unchanged. In 2000, the year-round population was 6080 and in 2010 the population was 6061. During the summer months, the region's population triples to 19,900.[10]

[10] Lisa Kristoff and Katrina Clark, "New task force addresses hospital changes," *Boothbay Register*, Aug. 24, 2012, available at http://74.121.198.194/article/new-task-force-addresses-hospital-changes/2141.

THE DECISION TO CLOSE ST. ANDREWS HOSPITAL

On July 30, 2012, the Board of Trustees of LCH announced its plans to close St. Andrews, the only hospital on the Boothbay peninsula, and convert it into an outpatient health care center. According to these plans, as of April 2013 *or sooner*, St. Andrews will no longer be licensed as a hospital. It will no longer provide 24/7 ED services, inpatient services, or surgical services. In place of the hospital, LCH will substitute a small urgent care center with limited hours and capabilities as compared to an ED. The urgent care center will be open only from 8:00 AM to 6:00 PM (8:00 AM to 8:00 PM during the summer). It isn't even clear whether such a center would be open more than five days per week.[11] The LCH plan proposes that, after St. Andrews closes, Boothbay peninsula patients needing care outside of these hours for ED-level services will need to travel to Miles in Damariscotta for emergency health care services – nearly 20 miles away and at least a 30-minute drive. The next-closest hospital is Mid-Coast Hospital in Brunswick, which is at least 30 miles away and a 45-minute drive from St. Andrews.[12]

Closing St. Andrews is a breach of trust to the residents of the Boothbay peninsula, St. Andrews' supporters and benefactors, and to St. Andrews employees and clinicians.

As explained below, the closing of St. Andrews will (i) divert charitable assets donated by people on the Boothbay Peninsula toward purposes not intended by the donors and benefactors, removed from the Boothbay peninsula altogether, and/or wholly wasted; (ii) be wholly inconsistent with the terms of the Definitive Agreement memorializing MaineHealth's takeover of St. Andrews in 1997; and (iii) significantly and adversely effect both the health care and the economy of the Boothbay region.

Despite the significant negative impact MaineHealth's and LCH's decision will have on St. Andrews and the region, this decision was made in a closed and non-transparent way. MaineHealth and LCH did not attempt to obtain any input from the Boothbay peninsula communities and patients served by St. Andrews regarding the decision to fundamentally eliminate a valuable community asset. MaineHealth and LCH failed to even provide notice to the communities that this decision would be made despite knowing that the option of closing the ED was on the table since at least April 2012.[13]

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[11] As of October 9, more than *two months after* LCH made its decision to convert St. Andrews' ED to an urgent care center, LCH Vice President for Hospital Operations, Cindy Leavitt, said that LCH was still looking specifically at what it means to be an urgent care facility, still needed to address reimbursement and regulatory questions, and was looking to visit other urgent care facilities in the state. *See* Sue Mello, "Lincoln County Healthcare moves forward," *Boothbay Register*, Oct. 9, 2012, available at http://www.boothbayregister.com/article/lincoln-county-healthcare-moves-forward/4260. It remains unclear whether LCH has addressed these important questions regarding the services that are supposed to replace the ED. The fact that these questions remained outstanding two months after the decision to close the ED raises additional questions about whether LCH's and MaineHealth's decision is in the best interests of the Boothbay Region communities.

[12] A map of the region is attached as Exhibit 6.

[13] *See* Navigant, *Lincoln County Healthcare Strategic Plan Implementation Assistance Progress Update*, at 27 (April 5, 2012) (hereinafter "April Navigant Report"). A copy of the PowerPoint presentation slides is attached as Exhibit 7.

The residents of the Boothbay peninsula communities are shocked, and worried, by MaineHealth's and LCH's sudden closure decision and the adverse impact that the closure decision will have on the communities and residents on the Boothbay peninsula. By way of example, in a survey of residents at the polls on Election Day, there was an overwhelming response from Boothbay peninsula residents opposing the proposed hospital closure. Attached is a summary description of a petition signed by Boothbay region residents as Exhibit 8. Having not had an opportunity to participate in the decision-making process regarding closure St. Andrews, members of these communities have formed the St. Andrews Task Force. The Task Force is a joint effort by residents of the towns of Boothbay, Boothbay Harbor, Southport, and Edgecomb to object to closure of St. Andrews.

MAINEHEALTH'S AND LCH'S PROPOSED ACTIONS ARE A BREACH OF TRUST

Pursuant to 5 M.R.S.A. § 194 ("Section 194"), the Attorney General has the authority to "enforce due application of funds given or appropriated to public charities within the State and prevent breaches of trust in the administration of public charities." *See In re Estate of Thompson*, 414 A.2d 881, 890 (Me. 1980) (". . . the Attorney General's duty to protect the community interest in [charitable trust] enforcement is not only derived from the common law, but is imposed by legislative mandate.") "Public charities," within the meaning of Section 194, include public benefit corporations formed under Title 13-B, such as St. Andrews, LCH, and MaineHealth. *See* 5 M.R.S.A. § 194(1).

MaineHealth's and LCH's proposal to terminate St. Andrews' hospital status constitutes a breach of trust subject to Attorney General enforcement. Maine courts have not had an opportunity to define "breaches of trust" as this phrase relates to nonprofit corporations, and there is scant legislative history on the subject. However, the Attorney General's Maine Consumer Law Guide provides a helpful starting point: "Charities are prohibited from soliciting charitable donations and then using the money for purposes other than what was promised would be done." "Maine Consumer Law Guide," § 25.5. This guidance, and the authority granted to the Attorney General by the Legislature under Section 194, is relevant here in that (i) MaineHealth's and LCH's proposal to terminate St. Andrews' hospital status breaches the trust of St. Andrews' supporters and benefactors, and (ii) as the corporate parents of St. Andrews, MaineHealth and LCH have breached their trust with respect to St. Andrews.

A. Breach of Trust to St. Andrews's Supporters and Benefactors

St. Andrews has benefited substantially from the generous support of the Boothbay Region communities in the forms of philanthropic giving, local tax exemptions, and other community contributions. This support has been given to St. Andrews for the purpose of supporting St. Andrews as a hospital. This has been St. Andrews' purpose since it was first founded by Dr. Gregory in 1905 and since St. Andrews was incorporated in 1955. St. Andrews' major charitable purpose, as described in its Articles of Incorporation, is clear: "[t]o establish, operate and maintain for scientific, charitable, educational and benevolent purposes a *public hospital*, clinic, infirmary and retirement community for the care and treatment of sick, wounded, infirm or aged persons, a doctors' office building and a school for the education and training of nurses" (emphasis added). *See* Exhibit 9. MaineHealth's and LCH's pending action will by

necessity require that most or all of St. Andrews' hospital assets be diverted toward purposes not intended by St. Andrews' donors and benefactors, removed from the Boothbay peninsula, and/or wasted.

MaineHealth and LCH should not be permitted to divert, remove, or waste these assets. These actions would be contrary to St. Andrews' primary charitable purpose and, as a consequence, a violation of the Maine Nonprofit Corporation Act (the "Act"). The Act limits how public benefit corporations may use their assets by prohibiting them from acting[14] beyond the scopes of their purposes. The Act authorizes public benefit corporations to take a wide variety of actions, including disposition of property. *See* 13-B M.R.S.A. § 202(1). However, the articles of incorporation may limit the powers that the nonprofit may exercise under § 202(1). *See id.* at § 202(2) ("The articles of incorporation of any corporation subject to this Act may limit the powers conferred by subsection 1, except to the extent that any such limitation is inconsistent with any provision of this Act or with any other law of this State."). Here, St. Andrews' Articles are quite clear that one of its primary purposes is to maintain a public hospital,[15] a purpose that the Boothbay peninsula residents and communities have supported to the tune of millions of dollars over the years. A listing of donations to St. Andrews is attached as Exhibit 10.

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[14] *See* American Bar Association, Committee on Nonprofit Corporations, "Model Nonprofit Corporation Act," cmt. to § 3.04 (3rd) ("Corporate action also includes inaction or refusal to act.").

[15] Admittedly, the Act would permit St. Andrews to amend its Articles of Incorporation, even to eliminate its primary purpose to maintain a hospital, provided that St. Andrews provides notice to the Attorney General in its filings that the Articles will be amended. *See* 13-B M.R.S.A. §§ 801, 802. However, an amendment to the Articles that changes St. Andrews' purpose would not permit St. Andrews to divert its assets to the new purpose in complete disregard of the purpose for which the assets were originally donated (namely, to support a hospital). First, the Act expressly provides that a nonprofit's duties and responsibilities survive the amendment to its Articles:

> No amendment shall . . . relieve the corporation of any liability already created or assumed, or effect any existing cause of action in favor of or against the corporation, or any pending suit to which the corporation shall be a party, or the existing rights of persons other than members, but for all such purposes the corporation, although operating under the amended articles of incorporation, shall be regarded as the same corporation.

13-B M.R.S.A. § 804(2). Second, nonprofit corporations do not have unfettered discretion to apply charitable assets whenever the directors decide to amend the articles. We are not aware of a Maine case on this issue, but the Massachusetts Supreme Judicial Court rejected giving nonprofit corporations this discretion, because in effect "[t]he public could not be assured that funds it donated would be used for similar public charitable purposes." *See Attorney General v. Hahnemann Hospital*, 494 N.E.2d 1011, 1021 (Mass. 1986). Furthermore, the Massachusetts court concluded that "[s]uch an interpretation also might eviscerate the Attorney General's power and responsibility to 'enforce the due application of [charitable] funds . . . and prevent breaches of trust in the administration thereof.'" *See id.* (quoting M.G.L., Ch. 12, § 8: "The attorney general shall enforce the due application of funds given or appropriated to public charities within the commonwealth and prevent breaches of trust in the administration thereof."). Going further, the South Dakota Supreme Court concluded in *Banner Health System v. Long*, 663 N.W.2d 242, 250 (S.D. 2003), that "[t]o the extent that the Attorney General is able to prove that amendment of the articles affected the rights of nonmembers, we believe that a constructive charitable trust may be imposed on those assets donated to the local facilities before [the parent corporation] amended its articles of incorporation. Any other rule of law would allow a charitable nonprofit corporation to eviscerate the charitable purpose for which it was formed without recourse for those who donated funds for that purpose. This result would be untenable because 'the public could not be assured that funds it donated would be used for [proper] similar public charitable purposes.'" (quoting *Hahnemann*, 494 N.E.2d at 1021).

Now, MaineHealth and LCH have unilaterally decided, without community input, that St. Andrews will no longer engage in its community-supported primary purpose – a primary purpose that was made possible through generous community support over the last 100 years. This is a violation of law and a breach of trust with the State, St. Andrews' supporters and benefactors, and the Boothbay peninsula communities. These assets do not belong to the board, the management, or the sole corporate member of St. Andrews. *See In re Manhattan Eye, Ear & Throat Hospital*, 186 Misc.2d 126, 151 (N.Y. Sup. Ct. 1999) ("A charitable board is essentially a caretaker of the not-for-profit corporation and its assets.").

Instead, the assets belong to the communities that have showered benefits on the nonprofit over the years, supporting and maintaining its essential purpose as a hospital. Therefore, St. Andrews' charitable assets should remain dedicated to the purposes intended by the donors and benefactors (a purpose that is still very much viable), and as stated in its Articles of Incorporation: a hospital on the Boothbay peninsula.

B. Breach of Trust to St. Andrews

In 1997, St. Andrews affiliated with MaineHealth's predecessor corporation, Maine Medical Center Foundation ("MMCF") (for purposes of clarity, MMCF is referred to as its current name: MaineHealth). St. Andrews and MaineHealth consummated the affiliation through the "Definitive Agreement," by which St. Andrews became a subsidiary corporation of MaineHealth, and MaineHealth became St. Andrews' sole corporate member. *See* Definitive Agreement at §§ 1.1, 1.4(a). MaineHealth has breached certain covenants contained in the Definitive Agreement, and in turn, has breached the trust of St. Andrews.

Closing St. Andrews is inconsistent with the Definitive Agreement

In agreeing to this affiliation, St. Andrews' governing board entrusted MaineHealth with significant decision-making authority over St. Andrews, including adoption of budgets, election of St. Andrews' governing board, selection of St. Andrews' chief executive (who would report to MaineHealth), and implementing and terminating new and existing programs and services. *See* Definitive Agreement at § 1.4(a). In return, among other things, MaineHealth agreed that it would be

> "committed to maintain at a minimum 24 hour emergency services . . . in the Boothbay Harbor region" as part of MaineHealth's system.

See id. at § 2.1. This section of the agreement provides that the MaineHealth-approved St. Andrews governing board could terminate such services as it deems "no longer necessary and appropriate." However, this section also requires MaineHealth's board to "develop in cooperation with St. Andrews a recommended process, including criteria, to be used by it in developing a plan for analyzing and implementing consolidation of clinical services." *See id.* Moreover, MaineHealth is required to cooperate with St. Andrews "to reduce costs *without sacrificing access* to, or the quality of, the healthcare services provided." *See id.* at § 2.3(b) (emphasis added). Notably, the Definitive Agreement contains no express provision sanctioning St. Andrews' loss of its hospital status. Furthermore, St. Andrews' Articles of Incorporation amended for the affiliation, retained St. Andrews primary purpose of maintaining a hospital.

St. Andrews, as well as the leaders of the communities served by St. Andrews (many of whom were integral to the negotiations during MaineHealth's takeover bid), would not have agreed to a takeover of St. Andrews if hospital closure, or any substantial change in health care services, was a possibility. Community leaders who directly participated in the 1997 negotiations with MaineHealth have stated that MaineHealth specifically reassured St. Andrews that: (i) hospital closure was not a possibility, and (ii) St. Andrews would always have the ability to walk away from the affiliation.

MaineHealth also promised to "cooperate with [St. Andrews and Miles] on the analysis and implementation of consolidation of services and development of new services in Lincoln County, Maine." *See id.* at §§ 2.4, 3.1. After MaineHealth and Miles affiliated, MaineHealth and St. Andrews amended their Definitive Agreement to create a process by which MaineHealth and St. Andrews could terminate their affiliation. The process requires the parties to enter non-binding mediation, and if the mediation does not create progress, the affiliation could be terminated if the governing boards of MaineHealth and St. Andrews adopt resolutions authorizing termination. *See* Amendment to Definitive Agreement, § 9.6. For all practical purposes, however, MaineHealth controls whether the affiliation may be terminated, given the fact that MaineHealth elects all of St. Andrews' trustees.

Contrary to the language of the Definitive Agreement, MaineHealth's and LCH's decision will sacrifice the Boothbay Region's access to critical health services. This decision stemmed from a process that could hardly be called "cooperative." Because LCH's, Miles' and St. Andrews' Boards are elected by MaineHealth and Miles-led, it is difficult to know whether a St. Andrews' Board representative of the communities St. Andrews actually serves would have opposed the decision to close St. Andrews and/or voted to terminate the affiliation with MaineHealth. Moreover, because of the secretive nature of the decision, complete lack of community input into the decision-making process, and the outcry of the communities in response to the decision, St. Andrews' level of support for the decision and MaineHealth's (and LCH's) level of cooperation are in question. As a result, for the reasons set forth below, MaineHealth and LCH have breached the duties that they owe to St. Andrews.

MaineHealth and LCH have breached their fiduciary duty to St. Andrews and the Boothbay peninsula communities it serves

Under the Definitive Agreement, St. Andrews placed its operations and its charitable purposes in the care of MaineHealth, and MaineHealth agreed to cooperate with St. Andrews and protect the Boothbay peninsula's access to health care. The power structure between the two organizations is such that MaineHealth unquestionably has ultimate control over St. Andrews and its assets. In addition, by affiliating with St. Andrews and not amending St. Andrews' Articles of Incorporation, MaineHealth implicitly agreed to be a steward of St. Andrews' main charitable purpose of operating a hospital. These circumstances, when taken together and in the context of the closing of St. Andrews, demonstrate that MaineHealth assumed a fiduciary duty to St. Andrews and breached it.

Under Maine law, a fiduciary relationship exists if two elements are met: (i) one party actually puts trust and confidence in another, and (ii) there is a significant disparity between the

parties in terms of position and influence. *See Diversified Foods, Inc. v. First Nat. Bank of Boston*, 605 A. 2d 609, 614 (Me. 1992); Horton & McGehee, *Maine Civil Remedies* (4th ed.), § 9-3(d). Fiduciary duties are imposed on the party in the superior position. *See Diversified Foods, Inc.*, 605 A.2d at 614-15. Once a fiduciary relationship is found to exist, a presumption of undue influence and unfairness attaches to any transaction between the two parties, with the superior party bearing the burden of showing that the transaction was fair and free of undue influence. *See Ruebsamen v. Maddocks*, 340 A.2d 31, 36 (Me. 1975); Horton & McGehee, *supra*, at § 9-3(d).

It does not appear that Maine courts have had an opportunity to opine whether a fiduciary relationship arises out of a parent/wholly-owned subsidiary relationship between public benefit corporations. However, the Rhode Island federal district court, at the urging of the Massachusetts Attorney General, concluded that under Massachusetts law a fiduciary relationship existed between a nonprofit health system parent and its wholly-owned nonprofit subsidiary hospital. *See Lifespan Corp. v. New England Medical Center, Inc.*, 731 F.Supp.2d 232 (D.R.I. 2010). Similar to the MaineHealth-St. Andrews relationship, Lifespan became New England Medical Center's ("NEMC") sole corporate member, *id.* at 236, and controlled key aspects of NEMC's operations, including strategic planning, election of board members, and selection of the chief executive who would report to Lifespan. *Id.* at 240. Given the control that NEMC ceded to Lifespan, the district court concluded that there was "no doubt that NEMC reposed faith, confidence, and trust in Lifespan's judgment and advice when it joined Lifespan's healthcare system." *Id.*

The district court acknowledged that the general rule is that a corporate parent does not owe a fiduciary duty to its wholly-owned subsidiaries. *See id.* With respect to nonprofit organizations, however, the court found that "the analysis changes somewhat":

> The concern there is not with competing shareholder interests, but with competing charitable objectives between parent and subsidiary. Even where the parent is the subsidiary's sole voting member, they may have different aims and different benefactors. This is particularly true in the case of healthcare systems, where the interests of the system as a whole may diverge from those of a given hospital. In significant respects, the benefactors of the hospital, namely its *patients and community*, stand in a position similar to the minority shareholders in a non-wholly-owned, for-profit subsidiary,[16] in that they are vulnerable to the power of the controlling entity.

Id. (internal quotations and citations omitted) (emphasis added). In other words, hospital subsidiaries repose "special confidence and trust in the system, which result[s] in a position of superiority on the part of the system, the very essence of a fiduciary relationship." *Id.* at 240 (quoting *Health Alliance of Greater Cincinnati v. Christ Hosp.*, 2008 WL 4394738 (Ohio App. Ct. Sept. 30, 2008)) (internal quotation marks omitted).

[16] Similarly, the Law Court has held that majority shareholders in a closely-held corporation owe a fiduciary duty to minority shareholders. *See Moore v. Maine Industrial Services, Inc.*, 645 A.2d 626, 628-29 (Me. 1994).

The facts that gave rise to a fiduciary duty in *Lifespan* also give rise to a fiduciary duty in this instance. St. Andrews and NEMC each entrusted their respective health systems to manage their affairs in strikingly similar ways. Thus, as the only hospital on the Boothbay peninsula, St. Andrews entrusted to MaineHealth the Boothbay peninsula's ready access to health care services, and as the *Lifespan* court put it and is made clear today, the well-being of the region is vulnerable to the decisions of MaineHealth. Accordingly, St. Andrews' two parent organizations, LCH and MaineHealth, owe a fiduciary duty to St. Andrews and the Boothbay peninsula communities, and should have to prove that their actions toward St. Andrews were fair and free of undue influence.

However, the unilateral and private manner in which LCH and MaineHealth have made their plans for St. Andrews, and LCH's and MaineHealth's failure to seriously and fairly examined alternatives to terminating St. Andrews' hospital status, is at the very least questionable and, with respect to the Definitive Agreement, contrary to MaineHealth's promise "to reduce costs without sacrificing access to, or the quality of, the healthcare services provided."[17] Definitive Agreement, § 2.3(b).

Further, MaineHealth and LCH may have breached their fiduciary duties to St. Andrews by hampering St. Andrews' ability to carry out its charitable mission. Since this corporate restructuring, it is clear that Miles has benefitted to the detriment of St. Andrews' charitable purposes. First, LCH's management consists of Miles's management, thus impeding St. Andrews' ability to advocate within LCH for itself and the Boothbay peninsula communities. Jim Donovan, the CEO of Miles, is also the CEO of LCH (and St. Andrews). Second, LCH has engaged in a steady erosion of St. Andrews' services, which has imperiled St. Andrews' ability to provide critical access hospital services, and which services have been shifted to Miles. In 2010, St. Andrews' inpatient surgical and acute care programs were terminated. This past April, St. Andrews' outpatient surgical services and remaining inpatient services were terminated.

St. Andrews' charitable assets should be protected from waste and diversion by MaineHealth and LCH, whether this comes (hopefully) in the form of MaineHealth and LCH maintaining St. Andrews Hospital, the spin-off of St. Andrews into an independent hospital, or preserving St. Andrews' assets in a constructive charitable trust for the purpose of maintaining a hospital on the peninsula.[18]

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[17] A New Hampshire matter involving a similar situation, while distinguishable in some ways, is illustrative. In March 1998, the New Hampshire Attorney General issued a report on Optima Health. A copy of the report is attached as Exhibit 11. Optima was the parent organizations of two merged Manchester, NH, hospitals: Elliot Hospital ("Elliot") and Catholic Medical Center ("CMC"). In 1994, the hospitals merged into Optima, and at the time, the hospitals said they would continue to operate after the merger. However, after the merger, the separate corporate identities of the hospitals were stripped and control transferred to Optima. In addition, Optima decided to consolidate all acute care services at the Elliot campus and make CMC a rehabilitation and psychiatric unit, despite the fact that CMC's primary purpose was to operate a hospital. This decision was made without public input. As a result of these and other actions, "two special boards of trustees, appointed by agreement between the attorney general and Optima, decided that *Elliot and CMC should disaffiliate and that each should separately serve as an acute care hospital.*" (Emphasis Added) *See Petition of CIGNA Healthcare, Inc.*, 777 A.2d 884, 886 (N.H. 2001).

[18] There are multiple bases for applying a constructive charitable trust, but the one that seems most applicable at this point in time is MaineHealth's and LCH's abuse of their fiduciary relationships to St. Andrews. *See* Horton & McGehee, *supra*, at § 9-3(d) (abuse of fiduciary relationship as a basis for imposing a constructive trust). (Discussion of the imposition of a constructive charitable trust as a result of a change in a public benefit

MAINEHEALTH'S AND LCH'S PROPOSED ACTIONS ARE *ULTRA VIRES*

As described above, a public benefit corporation is required to act within the scope of its charitable purposes as prescribed in the corporation's articles of incorporation. *See* 13-B M.R.S.A. § 202(2). As also described above, MaineHealth's and LCH's proposed plan to terminate St. Andrews' hospital status is clearly contrary to St. Andrews' primary purpose as provided in its articles of incorporation. Although the Attorney General has authority under Section 194 to take enforcement action against public benefit corporations for such *ultra vires* actions, the Act provides the Attorney General with additional authority. The Attorney General may assert that a public benefit corporation lacks authority to take an action (or fail to act) "[i]n a proceeding by the Attorney General, as provided in this Act, to dissolve the corporation, or in a proceeding by the Attorney General to enjoin the corporation from performing unauthorized acts, or in any other proceeding by the Attorney General." *Id.* at § 203(1)(C). Accordingly, the Attorney General may take action to enjoin MaineHealth and LCH from terminating St. Andrews' hospital status and take actions to ensure that St. Andrews' hospital license remains in good standing.

CLOSING ST. ANDREWS WILL NEGATIVELY IMPACT THE HEALTH AND WELL-BEING OF BOOTHBAY PENINSULA PATIENTS

A. Continuing Patient Need for ED-Level Services at St. Andrews

St. Andrews is a federally designated Critical Access Hospital. It is exactly the type of facility the federal government sought to preserve when it created the CAH program. The principal purpose of the CAH program is *to improve rural health care access and reduce*

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corporation's articles of incorporation is at footnote 15.) Although we are unaware of any Maine case law on the topic of constructive or implied charitable trusts, there is precedent to apply this kind of trust upon a charitable organization.

In *Banner Health System*, the court recognized the theory of constructive charitable trust based on the theories of unjust enrichment, breach of fiduciary duties, and improper amendment of the charitable corporation's articles of incorporation. *Banner Health System*, 663 N.W.2d at 248. In this case, an out-of-state nonprofit health system sold in-state nonprofit health care facilities with the intention of transferring the proceeds of the sales to the system's out-of-state facilities. *Id.* at 246. The South Dakota Attorney General intervened and argued that the proceeds could be restricted by constructive charitable trusts and could not be removed from the state. *Id.* The court agreed with the attorney general, first concluding that South Dakota's nonprofit corporation statute did not preclude application of common law and statutory trust principles to a nonprofit corporation, *see id.* at 247, and then concluding that a constructive charitable trust may be imposed on property given to a nonprofit corporation for the purpose of supporting its declared charitable purposes. *See id.* at 249.

The conclusions of the *Banner Health System* court are applicable here. Although there does not appear to be the potential that St. Andrews' charitable assets will be moved out of Maine, there is the distinct potential that the assets will be removed from the Boothbay Region, contrary to the intentions of the donors and the charitable purposes of St. Andrews and the intentions of donors. In addition, with respect to the Act, we can find nothing in the Nonprofit Corporation Act indicating that the Legislature intended to preclude the use of equitable remedies, such as constructive charitable trusts, against public benefit corporations. Accordingly, equitable remedies may be imposed against St. Andrews, LCH, and MaineHealth to protect the charitable assets from being used, diverted, or wasted in a manner contrary to the intentions of the donors and the purposes of St. Andrews.

hospital closures, with an emphasis on improving rural emergency medical services. In return for CAHs providing essential services to rural communities (e.g., CAHs must provide 24-hour emergency services), they are favorably reimbursed by Medicare. Because Maine is a rural state, with many remote, rural hospitals, it is not surprising that there are 16 CAHs in the state. These hospitals are vital to the health care needs of the patients in the communities they serve. St. Andrews is no different.

Despite LCH's plans to close St. Andrews Hospital, Boothbay peninsula patients' needs for hospital and ED services will remain, and likely increase. The St. Andrews Task Force has engaged a health care consulting firm to review these patients' needs in greater detail. A copy of the report will be circulated as soon as it is available.[19]

First, an urgent care center will not be able to appropriately care for seriously ill or injured patients. Nearly 20 percent of visits to St. Andrews' ED required care that goes beyond the scope of an urgent care center. Between February 1, 2011, and January 31, 2012, St. Andrews' ED experienced 4,601 visits.[20] Of these visits, 474 of these visits were classified as level 4 acuity.[21] A patient with level 4 acuity is a patient that should be seen in the ED immediately.[22] Approximately 380 more of these 4,601 visits were classified as level 5 acuity.[23] A patient with level 5 acuity is a patient needing life-saving intervention.[24] Consequently, St. Andrews saw 854 patients needing immediate or life-saving interventions during the one-year period ending January 31. These patients must be seen in an ED, not an urgent care center.

Second, the proposed urgent care center's hours are limited to 8:00 AM to 6:00 PM (8:00 AM to 8:00 PM during the summer) and many of the visits to St. Andrews' ED fall outside of these hours. It remains unknown whether the proposed center would be open on weekends or holidays. Between February 1, 2011, and January 31, 2012, St. Andrews' ED saw 883 patients of all acuity levels between 8:00 PM and 8:00 AM.[25] During the non-summer months when the urgent care center will be closed from 6:00 PM to 8:00 PM, St. Andrews' ED provided emergency care to approximately 270 patients. In total, during the above-referenced timeframes, St. Andrews' ED provided emergency care to approximately 1153 patients, or 25% of St. Andrews' ED's yearly patient volume, during hours when the urgent care center would be closed.

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[19] MaineHealth and LCH commissioned their own consulting report – the Navigant, *Lincoln County Healthcare Strategic Plan Implementation Assistance Progress Update*. However, MaineHealth and LCH did not include the residents and leaders of the Boothbay peninsula communities, or clinicians, employees and patients at St. Andrews, in this process.

[20] *See* April Navigant Report at 23. This is a significant increase from the period of April 1, 2010, through March 31, 2011, when St. Andrews' ED saw 4,199 visits. *See* Maine Hospital Association Financial Statistical Report for April 1, 2010, through March 31, 2012, at 36.

[21] *See* April Navigant Report at 26.

[22] *See* U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition," chapter 2, available at http://www.ahrq.gov/research/esi/esi2.htm (hereinafter, "ESI Handbook"). Please note that the ESI uses a scale of 1 to 5 for least serious to most serious, while the Navigant study uses a scale of 5 to 1 for least serious to most serious. For example, a level 5 patient on the Navigant scale would be a level 1 patient on the ESI scale.

[23] *See* April Navigant Report at 26.

[24] *See* ESI Handbook, chapter 2, available at http://www.ahrq.gov/research/esi/esi2.htm.

[25] *See* April Navigant Report at 24.

It is clear that there is substantial patient demand for St. Andrews' ED. Although it is possible that some of the visits to St. Andrews' ED can be handled adequately in an urgent care center, there are too many visits that still require the services that only an ED can provide.

This leads to the question of whether closing St. Andrews' ED is appropriate for the health needs of patients in the Boothbay Region, and consequently, a proper use of St. Andrews' assets. The nearest ED will be Miles, which is 20 miles away and a 30-minute drive from St. Andrews. This means that level 4 and level 5 patients will be spending 30 minutes more either in an ambulance or a private vehicle before receiving the services of an ED.

Another issue that arises from closing St. Andrews' ED is whether Miles will be able to adequately handle the increased volume of patients that would have gone to St. Andrews' ED. On three occasions over the past year, Miles has had to divert ambulances for two hours because of capacity issues.[26] In the case of a diversion, the ambulance may have to travel to Penobscot Bay Medical Center in Rockport, which is nearly 30 miles away from Miles and a 45-minute drive (at least 47 miles away and a 1 hour 5-minute drive from St. Andrews), or to Mid-Coast Hospital in Brunswick, which is nearly 25 miles from Miles and a 40-minute drive (at least 30 miles away and a 45-minute drive from St. Andrews). There may also be additional clinical impacts resulting from diversions and spending 40+ more minutes in an ambulance; if so, these adverse impacts will be identified in the report commissioned by the Task Force.

The primary reason MaineHealth and LCH provide in support of its decision to close St. Andrews' ED is based on quality concerns, not financial concerns.[27] According to LCH, the lack of volume of patients in St. Andrews' ED risks degrading the skills of ED personnel.[28] If this is LCH's primary concern, there are ways to ensure that St. Andrews' ED personnel see enough volume by rotating these personnel through MaineHealth's busier EDs, such as the EDs at Miles, Penobscot Bay Medical Center, Waldo County General Hospital and Maine Medical Center. Unfortunately, nothing indicates that this alternative solution merited any consideration by MaineHealth and LCH. Also, surprisingly, there has been no mention by MaineHealth and LCH of utilizing telemedicine to provide quality, state-of the art care to their patients. A copy of the article *Big Fish Eats Little Fish: Warning for Rural Hospitals* published by *Scientific American* blogger and Boothbay Harbor summer resident, Dr. Judy Stone, (September 25, 2012) is attached as Exhibit 12. MaineHealth and LCH also justify the decision to close the ED by pointing out that St. Andrews no longer has the ancillary services that are often used to treat ED patients, such as imaging and surgical services.[29] It is ironic that MaineHealth and LCH would rely on this justification, because MaineHealth and LCH systematically eliminated many of these services that used to be provided by St. Andrews. Essentially, MaineHealth and LCH are largely responsible for creating the quality concerns that they uses to justify their decision to completely shut down St. Andrews. Now, MaineHealth and LCH will have St. Andrews and the patients of the Boothbay peninsula communities bear the consequences of those decisions.

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[26] *See* Sue Mello, "A closer look at the ER," *Boothbay Register*, Sept. 12, 2012, available at http://www.boothbayregister.com/article/closer-look-er/3046.

[27] *See* Sue Mello, "Hospital decisions explained," *Boothbay Register*, August 1, 2012, available at http://www.boothbayregister.com/article/hospital-decisions-explained/1529. LCH's chief executive, Jim Donovan, has stated that the changes to be made to St. Andrews *will not result in savings*.

[28] *See id.*

[29] *See id.*

B. Impact of ED Closure on Community Resources

The closure of the St. Andrews' ED will also impact the communities in other ways. The Boothbay Region Ambulance Service ("Service") will certainly be negatively impacted by LCH's decision. The Service is a nonprofit corporation supported by the region's communities. Currently, the Service has a paid and volunteer staff of 40 and four ambulances.[30] Should St. Andrews' ED be closed, the Service will become an even more critical provider of health services, but unfortunately, the proposed closure will have significant negative effects on both the Service and the communities.

An ED closure will dramatically increase the Service's average run times and distances. Because the Service may not be able to deliver patients to St. Andrews after April 2013, most of these patients will probably be rerouted to Miles. In 2012, 49 percent of local ambulance calls required five miles of travel or less from the scene of the response to the hospital. The average distance traveled for an ambulance run is eight miles and the average run time is 30 minutes. With the closure of the St. Andrews ED, the average run time is expected to increase to over 90 minutes and the average run distance is expected to increase to 41 miles. These increases in run times and run distances will negatively affect the Service's finances, and accordingly, the Service's ability to provide ambulance service to the Boothbay Peninsula.

If the ED is closed, the Service's operating expenditures are expected to significantly increase. Recently, the Service revised its operating budget for the 2013 fiscal year to prepare for the impact of the ED closure. A copy of the Service's budgets for fiscal year 2012, fiscal year 2013 prior to the LCH announcement, and fiscal year 2013 accounting for LCH's announcement is attached as Exhibit 13. As a direct result of the planned ED closure, the Service's total operating expenditures for 2013 will increase by $151,306.88 to cover the costs of (i) more paid, highly-trained staff to stabilize patients during the longer trips to Miles, and (ii) a fourth ambulance to help cover the peninsula while the other ambulances are traveling to and from Miles. Additionally, the Service will lose the revenue it currently receives for transferring patients from St. Andrews. The Service anticipates that this will generate a loss of $200,000 per year. It is unlikely that this lost revenue will be made up by additional transfers from Miles.

These financial consequences will fall on the residents of Boothbay, Boothbay Harbor, and Southport, who will have to increase their monetary support of the Service by over 500%. The original 2013 budget had the Service receiving $80,464 in support from these three communities. With the impending ED closure, this amount must increase to $414,319.37. To pay for the increased assistance, the towns will each need to act to increase property taxes.[31] For the town of Boothbay, just to support the Service, the residents' property taxes will increase by 2.1%.

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[30] Information about the Boothbay Region Ambulance Service is derived from an interview with ambulance service supervisor, Scott Lash. *See* Sue Mello, "Ambulance prepares for ER closure," *Boothbay Register*, Aug. 15, 2012, available at http://www.boothbayregister.com/article/ambulance-prepares-er-closure/1924. The Service purchased its fourth ambulance for $175,000 (with $25,000 in charitable support). *See* Sue Mello, "Ambulance service gears up," *Boothbay Register*, Sept. 26, 2012, available at http://www.boothbayregister.com/article/ambulance-service-gears/3677.

[31] Boothbay: .16 mils; Boothbay Harbor: .24 mils; Southport: .06 mils.

CONCLUSION

St. Andrews has been a valuable institution to the Boothbay Region for over 100 years and, should MaineHealth's and LCH's proposal come to fruition, this institution will be fundamentally and permanently altered in a manner that adversely affects the people of the region.

Since 1997, MaineHealth and LCH, both nonprofit corporations, have been entrusted with the care and preservation of St. Andrews and its assets and the health and well-being of the region. As this white paper describes, St. Andrews has been the beneficiary of significant community support. This support was given to St. Andrews with the intent that St. Andrews would remain a licensed hospital serving the Boothbay Region providing critical services to support the region's health and well-being.

Maine Health's and LCH's decisions, namely the decision to close St. Andrews and terminate its hospital license, have placed these assets and the health and well-being of the Boothbay Region in serious jeopardy. Nevertheless, MaineHealth's and LCH's decision, which will significantly impact the region, was made without the input of the communities and individuals who have supported and relied upon St. Andrews over the past 100 years. Moreover, there is no indication that MaineHealth and LCH seriously considered alternatives to taking away the region's only hospital. This style of decision-making may be permissible in the for-profit, private business context. But St. Andrews is not simply a private corporate asset. MaineHealth and LCH are nonprofit corporations entrusted with responsibilities over St. Andrews and its charitable assets. As such, MaineHealth and LCH should be held to a higher standard and more rigorous scrutiny. Despite the efforts of the communities and the St. Andrews Task Force, MaineHealth and LCH have evaded serious scrutiny and are forging ahead with its plans despite a lack of community input.

For the above-stated reasons, the St. Andrews' charitable assets should be protected from waste and diversion by MaineHealth and LCH, whether this comes in the form of MaineHealth and LCH deciding to maintain St. Andrews as a hospital (hopefully this will be the case), the spin-off of St. Andrews into an independent hospital, or preserving St. Andrews' assets in a constructive charitable trust for the purpose of maintaining a hospital.

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