STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

PROVIDENCE, SC. **SUPERIOR COURT**

(FILED: January 7, 2015)

GARY J. GAUBE, Chief Executive Officer and Trustee, Plaintiff,	:	
v.	:	**C.A. No. PB 08-4371**
LANDMARK MEDICAL CENTER, Defendant.	:	
GARY J. GAUBE, Chief Executive Officer and Trustee, Plaintiff,	:	
v.	:	**C.A. No. PB 08-5893**
LANDMARK HEALTH SYSTEMS, INC., Defendant.	:	
RICHARD R. CHAREST, Chief Executive Officer, Plaintiff,	:	
v.	:	**C.A. No. PB 08-7186**
NORTHERN RHODE ISLAND REHAB MANAGEMENT ASSOCIATES, L.P., Defendant.	:	

DECISION

SILVERSTEIN, J. Before the Court for decision[1] is Prime Healthcare Services-Landmark, LLC's (Prime) Motion to Enforce the Court's November 26, 2013 Order Granting Special Master's Petition to Sell Assets to [Prime] Free and Clear of Liens, Claims and Encumbrances (the Motion to Enforce) pursuant to Super. R. Civ. P. 7(b)(1) (Rule 7(b)(1)). Prime seeks an

[1] The above-captioned matters have been treated as consolidated.

order from this Court decreeing that Prime is not bound to abide by the Medicaid managed care payment rates established under G.L. 1956 § 40-8-13.4 set forth in a contract between Prime and Neighborhood Health Plan of Rhode Island (NHPRI). By way of a motion to intervene (granted by the Court at the hearing on the Motion to Enforce on December 1, 2014), the Executive Office of Health and Human Services for the State of Rhode Island (EOHHS) filed an objection to Prime's Motion. NHPRI has relied on and joined in EOHHS' objection. While Prime argues the Court's November 26, 2013 Order (the Order) does not require it to be bound by any contracts rejected by the Special Master (including, inter alia, previously agreed Medicaid rates between NHPRI and Landmark Medical Center (LMC)), the fundamental issue before the Court is whether Prime is nonetheless required to conform to the rate methodology formulated pursuant to § 40-8-13.4 and implemented and enforced by EOHHS.

I

Facts and Travel

LMC operated a hospital principally located in Woonsocket, Rhode Island and, along with Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island (RHRI) and Landmark Health Systems, Inc. (LMS) (collectively Landmark), filed for the appointment of a Special Master on June 26, 2008. NHPRI is a Rhode Island not-for-profit corporation licensed by the Rhode Island Department of Business Regulation that operates a licensed health maintenance organization (HMO). EOHHS—a statutorily constructed executive agency[2]—contracts with NHPRI to provide health insurance coverage to Medicaid-eligible individuals.

[2] The EOHHS was established by the General Assembly pursuant to G.L. 1956 § 42-7.2-2 for the purpose of, among other duties, administering the federal and state medical assistance programs authorized under title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq. (2006). See §§ 42-7.2-1 et seq.

Rhode Island provides for the payment of in-state and out-of-state hospital services for eligible Medicaid recipients via two main types of health care delivery systems: fee for service Medicaid, which is non-managed care, and Medicaid managed care, in which the State contracts with a health care insurer (in this case, EOHHS contracted with NHPRI) for that insurer to pay monthly capitated amounts to health care providers (such as LMC) for the various Medicaid services. Pursuant to a Hospital Agreement between NHPRI and LMC dated August 1, 2007, the parties agreed to certain hospital payment rates for Medicaid managed care. Up until 2009, there was no set limit on fee for service Medicaid or Medicaid managed care payment rates.

Thereafter, the Special Master began a search for a new operator and owner of Landmark. In September of 2012, Prime and the court-appointed Special Master for Landmark executed an Asset Purchase Agreement (APA)—subsequently approved by the Court on October 18, 2012—whereby Prime agreed to purchase substantially all of the assets[3] owned by Landmark. The sale of Landmark's assets to Prime by the Special Master was expressly authorized by the Court in the November 26, 2013 Order. The closing date for the sale to Prime was December 31, 2013.

In relevant part, the Order granting the sale of the assets to Prime set forth the following provisions:

> "2f. The sale approved herein is not a de facto merger of the Hospitals and the Purchaser, is not a mere continuation of Defendants' operation of the Hospitals by Purchaser, and Purchaser is not otherwise a successor to the Hospitals, the Defendants, or the Special Master . . .
>
> "3. The Special Master is hereby authorized to sell, transfer, and convey all of his right, title, and interest in and to the Assets of the Hospitals as set forth in and in accordance with the terms of the APA, specifically including, but not limited to all of the Special Master's right, title and interest in and to all contracts, licenses, permits, and governmental approvals used in or pertaining to the Hospitals' operations, free and clear of all interests, claims, liens

[3] The term "assets" in this instance refers to the business operations and assets located at eight different locations in Rhode Island, as set forth in paragraph 1 of the Order.

> and encumbrances of any kind, nature or type whatsoever, however expressly excluding those interests, claims, liens and encumbrances specifically assumed by Purchaser in accordance with the APA . . . . Upon said sale, transfer, and conveyance, title in and to the Assets shall vest in Purchaser, free and clear of all interests, claims, liens and encumbrances of any kind, nature or type whatsoever, including but not limited to any claims for successor liability; however, those interests, claims, liens and encumbrances specifically assumed by Purchaser in accordance with the APA . . . shall remain with the Assets. . . .
>
> "4. This Court shall retain jurisdiction over the sale of the Assets to Purchaser pursuant to the APA annexed hereto, and this Court shall have sole and exclusive jurisdiction over any issues or disputes regarding the sale of the Assets and the APA . . . .
>
> "5. It is further understood, agreed and ordered that Purchaser is expressly rejecting and shall have no responsibility for those obligations identified in Section 1.5 of the APA and on certain Schedules and Lists of the APA, including, without limitation List 13.1(c), and Purchaser does not assume any liability, successor or otherwise, to those excluded obligations . . . ." Gaube v. Landmark Med. Ctr., No. PB-08-4371 (R.I. Super. Nov. 26, 2013); Gaube v. Landmark Health Sys., Inc., No. PB-08-5893 (R.I. Super. Nov. 26, 2013); Charest v. N. R.I. Rehab Mgmt. Assocs., LP., No. PB-08-7186 (R.I. Super. Nov. 26, 2013).

By letter dated December 30, 2013, the Special Master apprised NHPRI that Prime was electing not to assume (among other contracts that were rejected by the Special Master listed on List 13.1(c) of the APA), the Medicaid managed care payment rates contained in the agreement between NHPRI and LMC. After the closing of the sale, Prime and NHPRI began the process of negotiating Medicaid payment rates. On August 18, 2014, NHPRI advised Prime that it was required to comply with the Medicaid payment rates promulgated under § 40-8-13.4 and, accordingly, notwithstanding the rejection of the prior contract between NHPRI and LMC, the reimbursement rates that were in effect on June 30, 2010 should serve as the baseline for the subsequent rate increases under the statute (the Statutory Maximum Increases). Prime, however, rejected this contention, stating that it was not bound by the previous contracted rates based on the Special Master's rejection of the same on December 30, 2013.

This dispute between Prime and NHPRI regarding which payment rates should serve as the baseline rates under the statute led to Prime's filing of the instant Motion to Enforce on September 24, 2014. EOHHS filed its objection on November 7, 2014, and a hearing on the Motion was held on December 1, 2014.

II

Discussion

Prime is seeking a declaration from this Court as to whether its prior Order should apply so as to permit Prime to freely negotiate its own reimbursement rates with NHPRI as opposed to abiding by the rates previously established. The question presented is whether § 40-8-13.4 establishes the appropriate baseline for Medicaid managed care payment rates from NHPRI to Prime. The Court's ruling on this Rule 7(b)(1) motion—styled by Prime as a "Motion to Enforce" the Court's Order—inherently hinges on the Court's finding on this critical issue.

To properly analyze whether Prime is required to comply with § 40-8-13.4, a brief overview of the statute is necessary. As stated above, prior to the statute's enactment, parties were free to negotiate their own managed care rates. However, in 2009,[4] the General Assembly enacted § 40-8-13.4 with the express purpose of "implement[ing] a new methodology for payment for in state and out of state hospital services in order to ensure access to and the provision of high quality and cost-effective hospital care to its eligible recipients." Sec. 40-8-13.4(a). Effectively, the statute mandates that for both inpatient and outpatient services, "the Medicaid managed care payment rates between each hospital and health plan shall not exceed [90.1% or 100%, respectively] of the rate in effect as of June 30, 2010." Secs. 40-8-13.4(b)(1)(B), (b)(2). Once established, those baseline rates are subjected to the Statutory Maximum Increases outlined in the statutory scheme for the various, subsequent monthly periods

[4] Act of June 30, 2009, P.L. 2009, ch. 09-68 (09–H 5983A), art. 23, § 7.

through the next period beginning on July 1, 2015 where the "negotiated increases in inpatient hospital payments for each annual twelve (12) month period [thereafter] may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period." Sec. 40-8-13.4(b)(1)(B)(iii); see also § 40-8-13.4(b)(2) (outlining same rate increases with respect to outpatient services for Medicaid managed care). No Rhode Island court has yet to analyze this statute or its effect on current, then existing hospitals in the State or the statute's possible effect on any new entrant hospital (albeit, no new hospitals in Rhode Island have formed since the statute's enactment in 2009).

A

Receiver's Rejection of Contracts

As a threshold matter, and indeed an issue that bleeds into the Court's subsequent statutory interpretation of the statute's effect on successor entities of Rhode Island's current eleven hospitals, is Prime's contention that because the contract between LMC and NHPRI regarding Medicaid payment rates was expressly rejected by the Special Master, there can be no rate "in effect as of June 30, 2010" as required under § 40-8-13.4. Consequently, Prime argues they are not in violation of the statute in negotiating its own rates with NHPRI because there are no rates currently serving as the required baseline. Thus, Prime should be free to negotiate its own, more favorable reimbursement rates as a new entrant. Then, once that new base is established, Prime avers that it has to abide by the Statutory Maximum Increases in full accordance with the guidelines set forth in the statute.

The ability of a receiver[5] to reject a prior executory contact has been well-documented.[6] See, e.g., Moran v. City of Cent. Falls, 475 B.R. 323, 332 (D.R.I. 2012), appeal dismissed, No. 12-1670 (1st Cir. 2012); George Blum et al., 65 Am. Jur. 2d Receivers § 164 (2014) ("A receiver . . . may repudiate or reject the executory contracts of the owner of the estate that is being administered."). The rejection of a contract provides the receiver with an "opportunity to determine which of the prepetition executory contracts are beneficial to the estate and which should be assumed or rejected." See In re FBI Distribution Corp., 330 F.3d 36, 42 (1st Cir. 2003). Similar to the practice of rejecting contracts in bankruptcy cases, if a receiver assumes a contract, it assumes the contract cum onere, and all liabilities incurred in performing the contract are treated as administrative expenses. See id. (citing Bildisco, 465 U.S. at 531-32). However, if a receiver elects to reject a contract, the date of the rejection dates back to the date when the receivership began (in this case, June 26, 2008). See, e.g., Westinghouse Elec. & Mfg. Co. v. Brooklyn Rapid Transit Co., 6 F.2d 547, 548 (2d Cir. 1925); Ellsworth E. Clark et. al., Adoption and Rejection of Contracts and Leases by Receivers, 46 Harv. L. Rev. 1111, 1115 (1933).

It is uncontested that in the present matter, the 2007 Hospital Agreement providing for the Medicaid managed care payment rates between NHPRI and LMC was expressly rejected by the Special Master on December 30, 2013. Rather, EOHHS, in response, contends that regardless of that fact, there indeed were rates *in place* between NHPRI and LMC on June 30, 2010 that NHPRI had paid and Landmark received. Therefore, it is clear to the Court that it is now tasked with determining essentially whether § 40-8-13.4 imposes the ultimate obligation on Prime to assume those rates in place on June 30, 2010, irrespective of whether the Special Master

[5] In this matter, the Court, in previous Orders, cloaked the Special Master with all the powers of a receiver.

[6] The United States Supreme Court noted that "executory contracts" (as used in the context of the U.S. Bankruptcy Code) were intended to include those contracts "on which performance is due to some extent on both sides." N.L.R.B. v. Bildisco & Bildisco, 465 U.S. 513, 552 n.6 (1984) (internal quotation marks omitted).

expressly rejected that contract. This inquiry inherently requires a look to the legislative intent of the General Assembly in passing the statute. Essentially, the question to resolve now is: does the statute impose a set baseline rate for all hospitals then in existence—regardless of any subsequent change in ownership—or does the statute imply (by its silence) that Prime, as a subsequent owner of Landmark's assets, is free to establish its own baseline Medicaid rates.

B

Statutory Interpretation of § 40-8-13.4

As noted above, the main thrust of Prime's argument focuses on whether the General Assembly contemplated requiring a new entrant or successor entity to assume a previously established baseline rate in accordance with § 40-8-13.4. In effect, Prime is asserting that the statute's silence is effectively affirming that a new entrant is free to negotiate its own initial baseline rate, as was the case prior to the statute's enactment in 2009. Thereafter, Prime argues all subsequent increases would be governed by the statutory provisions and they would be operating in accordance with the statutory requirements. Any other outcome, Prime argues, would be in violation of the Court's Order approving the rejection of the prior rates contract listed in Section 1.5 of the APA.

On the other hand, EOHHS asserts that whether or not the contract was rejected misses the point—the exclusive methodology for rate setting was to apply to all licensed hospitals participating in managed care and not only those hospitals maintaining consistent ownership. More importantly, EOHHS contends there is nothing in the Order that prevents Prime from being bound by the previous rates because, even though the contract was rejected, it cannot now be exempt from the requirements of the statute to use the rates from June 30, 2010. Correspondingly, NHPRI argues that the consequence of Prime's excusal from the statutory requirement necessarily leads to NHPRI having to account for the shortfalls between the newly

negotiated reimbursement rates and the premiums it receives from the State when the State is using the June 30, 2010 rates. According to NHPRI, this detrimental result would occur at each Statutory Maximum Increase.

"'It is well settled that when the language of a statute is clear and unambiguous, [the] Court must interpret the statute literally and must give the words of the statute their plain and ordinary meanings.'" Iselin v. Ret. Bd. of Emps.' Ret. Sys. of R.I., 943 A.2d 1045, 1049 (R.I. 2008) (quoting Accent Store Design, Inc. v. Marathon House, Inc., 674 A.2d 1223, 1226 (R.I. 1996). A court must apply the statute as written when confronted with an unambiguous statute; however, when the court is faced with an unclear or ambiguous statute, the court is permitted to examine the statute in its entirety to give the statute the meaning that is most consistent with the policies and purposes of the Legislature. State v. Peterson, 722 A.2d 259, 264 (R.I. 1998). The court "glean[s] the intent and purpose of the Legislature 'from a consideration of the entire statute, keeping in mind [the] nature, object, language and arrangement' of the provisions to be construed . . . ." In re Advisory to the Governor (Judicial Nominating Comm'n), 668 A.2d 1246, 1248 (R.I. 1996) (quoting Algiere v. Fox, 122 R.I. 55, 58, 404 A.2d 72, 74 (1979)).

When more than one interpretation of the statute is possible, the court will not infer the Legislature to have intended unreasonable consequences. Algiere, 122 R.I. at 59, 404 A.2d at 74; see Kaya v. Partington, 681 A.2d 256, 261 (R.I. 1996) ("This court will not construe a statute to reach an absurd result."). "Although [this Court] afford[s] deference when a statute is susceptible to more than one reasonable interpretation and the agency charged with its enforcement has given an interpretation that is not clearly erroneous or unauthorized, [courts] retain 'final responsibility for statutory construction [.]'" Alba v. Cranston Sch. Comm., 90 A.3d 174, 180 (R.I. 2014) (quoting Asadoorian v. Warwick Sch. Comm., 691 A.2d 573, 577 (R.I. 1997)). The Court must remain mindful in interpreting a statute that "it is axiomatic that '[the]

Court will not broaden statutory provisions by judicial interpretation unless such interpretation is necessary and appropriate in carrying out the clear intent or defining the terms of the statute.'" State v. Santos, 870 A.2d 1029, 1032 (R.I. 2005) (quoting Simeone v. Charron, 762 A.2d 442, 448-49 (R.I. 2000)).

Here, § 40-8-13.4 has been subjected to varying interpretations by Prime and EOHHS. While an agency (here, EOHHS) is usually afforded some deference in its interpretation of a statute, Prime maintains that the Legislature, in not discussing the ramifications on the baseline rates in situations of a hospital's change in ownership, purposefully intended for such entities to negotiate their own rates. See Alba, 90 A.3d at 180. As Prime argues in its reply memorandum, the General Assembly was fully aware of the receiverships ongoing at LMC and Westerly Hospital, and through its silence, did not intend for any subsequent entities to be held to preexisting rates.

In relevant part, § 40-8-13.4 states "it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010." Sec. 40-8-13.4(b)(1)(B). Importantly, the statute also provides: "(v) All *hospitals* licensed in Rhode Island shall accept such payment rates as payment in full; and (vi) for all such *hospitals*, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program." Id. (emphasis added). What is not clear from the statute is the meaning of the term "hospital" with respect to the rates that were "in effect" as of June 30, 2010. Arguably, if the rates applied to all those hospitals then in existence, meaning the actual structure or facility housing the institution at that particular location, then it would not matter if Prime rejected LMC's contract with NHPRI because it nonetheless is required to follow the rate in effect on June 30, 2010, and that rate was the rate agreed to by LMC. However, Prime draws the

Court's attention to the words "in effect" as support for its contention because, if no rates were in effect on June 30, 2010 (as Prime's rejection of the contract for payment rates dates back to 2008, at the beginning of receivership), then it cannot possibly comport with the statute unless it develops its own rates.

It is without question that "[a] court need not lie supine in the face of legislative silence or ambiguity." Kaya, 681 A.2d at 262. Quite simply, however, "[i]t is not [the Court's] role to contort the language of an unambiguous statute in order to include within its reach a situation which it plainly does not encompass." Olamuyiwa v. Zebra Atlantek, Inc., 45 A.3d 527, 536 (R.I. 2012). Indeed, the Court "shall not interpret a statute to include a matter omitted unless the clear purpose of the legislation would fail without the implication." State v. Feng, 421 A.2d 1258, 1264 (R.I. 1980).

In this case, the Legislature has not provided any guidance in the statute on whether a successor or new entity purchasing assets of a former hospital is required to abide by that former hospital's Medicaid managed care payment rates. Thus, the result in this matter inherently hinges on the meaning of the term "hospital." "It is a fundamental principle that in the absence of statutory definition or qualification the words of a statute are given their ordinary meaning. What is crucial, however, is to determine the ordinary meaning *as of the time of enactment*." Chambers v. Ormiston, 935 A.2d 956, 961 (R.I. 2007) (emphasis in original) (internal citations and quotation marks omitted); see State v. Briggs, 58 A.3d 164, 168 (R.I. 2013) (quoting LaPlante v. Honda North America, Inc., 697 A.2d 625, 629 (R.I. 1997)) ("[Courts] are mindful that it is generally presumed that the General Assembly 'intended every word of a statute to have a useful purpose and to have some force and effect.'"). Moreover, as our Supreme Court explained in determining the meaning of a particular word used in a statue, reference to contemporary dictionaries is not only appropriate but helpful. Chambers, 935 A.2d at 961.

In this Court's opinion, it would create an unintended result of the Legislature for this Court to construe the term "hospital" to mean just the entity maintaining or operating the facility or institution. See Kaya, 681 A.2d at 261-62. Applying the aforementioned standards and using the literal meaning of the word "hospital,"[7] the Legislature intended the term to refer to the actual facility or building then in place, i.e., the eleven hospitals in Rhode Island that were in existence in 2010, including LMC. Accordingly, § 40-8-13.4 effectively sets the baseline rates as those rates set for the facility and not necessarily the rates for the entities in charge of their operation.[8] Even though Prime contends the silence of the General Assembly with regard to new entrants equates to Prime's ability to negotiate its own baseline, the Court believes this to be an exercise in contorting the language of the statute to reach a situation not intended by the Legislature. See Olamuyiwa, 45 A.3d at 536.

Plainly, § 40-8-13.4 does not purport to allow for a new entrant entity controlling an existing hospital to become excused from the requirements of the statute merely because the entity purchased that hospital's assets after the statute's enactment. It seems abundantly clear to

[7] Merriam Webster's dictionary defines "hospital" as "an institution where the sick or injured are given medical or surgical care." Merriam-Webster Online Dictionary (retrieved on Dec. 30, 2014 from http://www.merriam-webster.com/dictionary/hospital). As used in that definition, "institution" refers to "a place where an organization takes care of people for a usually long period of time" and "place" means "a building or area that is used for a particular purpose." Merriam-Webster Online Dictionary (retrieved on Dec. 30, 2014 from http://www.merriam-webster.com/dictionary/institution); Merriam-Webster Online Dictionary (retrieved on Dec. 30, 2014 from http://www.merriam-webster.com/dictionary/place). Therefore, using the ordinary meaning of the above words, it can be gleaned that the Legislature intended "hospital" in this statute to refer to the specific building or facility housing the institution. See Chambers, 935 A.2d at 961.

[8] The Court notes that the Legislature has, in fact, defined "hospital" throughout other titles and chapters, including other chapters in title 40, such as chapter 18 relating to long term home health care. See § 40-18-2(9) (defining "hospital" to mean "a hospital as defined in chapter 17 of title 23."). Section 23-17-2 defines "hospital" for purposes of licensing of health care facilities as "a person or governmental entity licensed in accordance with this chapter to establish, maintain and operate a hospital." G.L. 1956 § 23-17-2(8). While "hospital" in those contexts refers to the entity operating the institution, the Court believes the Legislature here, in § 40-8-13.4, intended "hospital" to refer to the facility itself and not the controlling entity.

the Court that the intent of the Legislature in enacting § 40-8-13.4 was indeed to provide for certain caps on spending for Medicaid. Allowing any entity who owns a hospital to enter the field and create its own baseline rates from which the subsequent Statutory Maximum Increases would be subjected to appears to do violence to the main purpose behind the statute. The Legislature was clearly apprised of LMC, along with Westerly Hospital's, receiverships in 2009 and in 2010, as discussed by the parties during the Motion hearing, thereby foreseeing the likelihood of potential new entities taking control over the hospitals after its passing of § 40-8-13.4.

With that in mind, the Court can infer that the rate methodology promulgated by the General Assembly in 2009 (as the only such methodology for determining Medicaid managed care payment rates) intended for the baseline rates for LMC (in effect on June 30, 2010) to be the actual rates used for the Statutory Maximum Increases for any and all subsequent owners or entities operating that facility.[9] Despite the Legislature's silence as to what should occur for a change in ownership of a hospital, this result does not lead to any unreasonable consequences or absurd results. See Kaya, 681 A.2d at 261; Algiere, 122 R.I. at 59, 404 A.2d at 74. Ultimately, applying this interpretation of the meaning of "hospital" to the statute, it is clear that Prime is required to use the rate of LMC in effect on June 30, 2010 as its baseline rate in its current negotiations with NHPRI.

[9] If a new hospital was to arise (a hypothetical twelfth hospital in Rhode Island), then that may present a wholly unique issue as to whether that hospital would be free to negotiate its own reimbursement rates with its healthcare insurer. That issue, however, is not now before the Court. Instead, it appears the statute unequivocally mandated all then-existing eleven hospitals in Rhode Island to abide by their respective rates in effect on June 30, 2010.

III

Conclusion

Based on the foregoing analysis, this Court denies Prime's Motion to Enforce seeking a declaration that the Court's Order need not abide by LMC's Medicaid managed care payment rates. Nothing in the Court's November 26, 2013 Order is harmed by the Court's conclusion that Prime must use LMC's agreed to rates with NHPRI as of June 30, 2010 for purposes of establishing the baseline rates under § 40-8-13.4. Accordingly, Prime's Motion pursuant to Rule 7(b)(1) must fail.

Prevailing counsel shall present an order consistent herewith which shall be settled after due notice to counsel of record.

RHODE ISLAND SUPERIOR COURT
Decision Addendum Sheet

TITLE OF CASE:	**Gaube v. Landmark Medical Center; Gaube v. Landmark Health Systems, Inc.; Charest v. Northern Rhode Island Rehab Management Associates, L.P.**
CASE NOS:	**PB 08-4371; PB 08-5893; PB 08-7186**
COURT:	**Providence County Superior Court**
DATE DECISION FILED:	**January 7, 2015**
JUSTICE/MAGISTRATE:	**Silverstein, J.**
ATTORNEYS:	
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For Defendant:	**See attached**

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