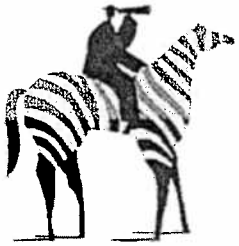
EXHIBIT C

Navigant Consulting Report dated November 9, 2006

Caritas Christi

Strategic Review Committee Meeting #3
November 9, 2006



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Section 1

Review and Today's Objectives

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Last Discussion Summary: Key Issues Facing CCHC

At the last meeting on October 10, we proposed that CCHC could survive in the market as a Catholic healthcare provider but will need to face and make some very tough decisions:

1. **Governance Model is Flawed** – system sponsorship must change/evolve
2. **Hub and Spoke system model has failed** – one or more campuses will require a rethinking of its "role"
3. **Restoration of credibility (Main Street and Wall Street) is critical** to go-forward success

Leadership, Management and Capital are the three necessary components to moving forward successfully.

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Today's Objectives

1. **Review 3-Year CCHC financial proforma and discussion of associate risk factors**
2. **Review four strategic options for CCHC including addressing of key outstanding items identified on October 10**
3. **Group discussion/recommendation**

Section 2

CCHC's Strategic Options

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Option 1: "A-Team" Board; Go Forward Strategy

Description: Create the "A" team system Board fully empowered to run the system without "interference" – allow this engaged, blue ribbon group to make decisions and empower management to execute go-forward strategy. System will need to develop and execute a variety of strategies, including a re-thinking of the roles of several of the campuses

Key Issues:

- Option only possible and viable with changes of substance to the role of the Archdiocese in CCHS governance – a slimming of the execution of the reserve powers would be the only way to attract the appropriate A-level candidates
- Go forward strategy will be very challenging, requiring a much deeper bench of stable management and very strong execution
- **Pros** – likely positive impact re: local politics, system retains local control over all decisions, stays Catholic, if execution is strong, Main Street/Wall Street credibility will return
- **Cons** – Appropriate level of capital investment difficult to get now, long period of "pain" in executing strategies, right leadership team difficult to find quickly
- Verdict re: Risk/Responsibility – FULLY RETAINED

Open discussion items to be addressed today:

- System 3-year financial proforma projections (led by Bob Guyon, CFO)
- Roles of system hospitals

Option 1: New Day, New Roles

In order for the system to move forward effectively and regain credibility, roles of the hospitals will need to be critically examined and re-evaluated.

SEMC: St. Elizabeth's continued perceived role as an "Academic Medical Center" system hub as a viable strategy is **strongly in question**; most likely option is to transition away from research and academic focus to a community hospital focus – looking only to direct cardiac services through the system and retaining only the tertiary services that it can support through the local service area.

While senior system leadership's view of SEMC is aligned (mostly) with this more appropriate vision, the **perception** of some local hospital leadership and most of the medical staffs is that the system intends for all or most referrals to be directed to SEMC and its medical staff.

Quote by local payer executive: *"Caritas continues to lose credibility while the system perpetuates the myth that St. Elizabeth's is competitive with the other AMCs in town."*

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St. Elizabeth's Medical Staff

- Since January, 2005, 17 primary care physicians have resigned from St. E's staff – leaving the organization with approximately 80 active adult PCPs (not including OB/Gyn and Pediatrics), about 50% of what a typical 300+ bed organization would need for support

- Recent departures have left St. Elizabeth's with some glaring holes in key subspecialties
  - Orthopedics
  - Pulmonary Medicine
  - General Surgery
  - Urology
  - GI
  - Cardiothoracic Surgery

  These specialties are needed for a strong community hospital, not to mention an academic teaching facility!

- Between January 2005 and now, 62 physicians in total have resigned from St. E's staff, while 23 physicians have resigned from the staffs of the other 5 hospitals combined

- While St. E's has mounted a significant recruiting effort since 2005 and recruited 50 new physicians, much of it has been "fire-fighting" (recruitment of hospital-based physicians needed to provide essential services that were interrupted by abrupt departures, e.g., radiology) rather than rebuilding the staff with primary care and/or high volume subspecialists.

St. Elizabeth's Ability to Drive Referrals Is Poor

PSA	Three Year Trend - St. Elizabeth's Market Share Within Individual Caritas Hospital PSAs											
	Cardiovascular Services			Oncology			Neurosciences			Orthopedics		
	FY 03	FY 04	FY 05	FY 03	FY 04	FY 05	FY 03	FY 04	FY 05	FY 03	FY 04	FY 05
St. Elizabeth's	8.7%	8.9%	9.3%	7.4%	6.9%	6.0%	7.3%	6.7%	6.9%	7.8%	8.1%	7.9%
Holy Family	7.7%	8.2%	10.1%	*	*	*	1.0%	*	*	*	*	*
St. Anne's	*	*	*	*	*	*	*	*	*	*	*	*
Norwood	3.4%	5.4%	4.3%	1.8%	2.7%	2.6%	1.7%	1.7%	2.2%	1.2%	1.6%	2.9%
Carney	3.0%	2.7%	2.9%	2.1%	1.7%	1.3%	1.0%	1.1%	1.2%	1.2%	1.2%	1.4%
Good Samaritan	4.2%	4.0%	4.6%	*	*	*	1.1%	*	1.2%	*	*	*

*** Indicates that St. Elizabeth's had less than 1% market share for this service line in the particular PSA**

- St. E's does not have significant market presence in any service in any market – not even getting to double digit market share in its own market
- The St. Elizabeth's cardiac market share in the Holy Family market has all but disappeared in FY 06 due to poor physician relationships/dynamics.

Conversion – the Brighton "Good Samaritan" (+ Hearts)

What might St. E's look like as a community hospital serving the Brighton/Alston communities and other near west towns?

Metric	St. Elizabeth's - Current Status	St. Elizabeth's – the local community hospital serving Brighton/Alston/Newton
Beds	300+ staffed, avg. occupancy of 60%	250 staffed – avg. occupancy of 80%+
Medical Staff	400+ active staff, 20% adult primary care	350 active staff, 40% adult primary care
Market position	3rd in the local market for high acuity care (CMI>1.5) behind Brigham and BID	#1 market position for low-med acuity care in the local PSA (CMI<1.5)
Teaching Programs	Primarily a fellowship feeding program; overly large Anesthesia residency and currently seeking additional accreditation for new fellowships	Downsize and refocus on residents interested in primary care medicine; goal to recruit 25% of annual graduates
Research	Operating at a $1M loss; $20M planned capital investment over next 5 years	No unfunded research or capital expenditures for research program
CMG	Large multispecialty group encompassing 90%+ of medical staff; group losses slowed through operational consolidation and move to productivity based comp model (upside but no downside)	Productivity-based comp has up AND down-side; explore additional models of economic alignment with physicians

Option 1: New Day, New Roles, continued

In order for the system to move forward effectively and regain credibility, roles of the hospitals will need to be critically examined and re-evaluated.

Carney Hospital: Economics and state of the facility combined with uncertain reimbursement scenarios make keeping Carney in the system and/or an acute care facility **strongly in question**; recommendation is to cease acute operations and transition to an alternative use or consider divestiture

St. Anne's: Currently in a vulnerable position due to relative isolation and comparative strength of local competition. Focused investment in key service areas (cancer, surgical services) will cement hospital position as a viable alternative and go-to location for certain services – a desirable position from the payer perspective.

Good Samaritan: Good opportunity for growth across the board, some good program foundations needing capital to realize growth potential; only one weak local competitor

Holy Family: While the market area is strong, recent leadership uncertainty, physician issues and a well-organized local competitor will make investment and execution very important in order to realize growth potential

Norwood: Has most opportunity due to lack of immediate area competition and relatively young facility – investment in a few key service lines may cement their position, especially prior to a suburban expansion on the part of NEMC/Baptist

Appropriate level of annual capital expenditures for Caritas should be ~$80-90M, with ~$40M for maintenance and replacement and $40-50M for growth and development. The current three year projections include $70 M per year in capital spending – a shortfall of $10-20M per year, not including pent-up capital needs across the system needs totaling ~$100M right now.

Carney Hospital Acute Service Trajectory is Not Favorable

While Carney is projected to have a positive bottom line in FY 07 ($854K), this is $600K less than FY 06 and the recent trends in volume along with a high degree of risk associated with the FY 07 budget assumptions make the future of acute care at Carney very uncertain.

	FY 04	FY 05	FY 06 (Projected)	FY 07 Budget	Trend FY 04-06
IP Discharges	6,358	6,110	5,913	5,999	↓
Outpatient Surgery	2,433	2,210	1,962	1,962	↓
Observation	813	798	507	507	↓
ED visits	30,842	30,189	28,978	28,978	↓
OP Clinic Visits	53,513	54,626	57,644	60,116	↑

Carney's FY 07 budget is highly dependent on:

- State grant money of $5.25M ($4M received; status of $1.25 unclear)
- Settlement of TCU Appeal for ~$2-3M (non-recurring Medicare settlement)
- Maintain FY 06 IP/OP volume (trends have been slightly downward over last 2 years)
- New MRI, PET/CT, chemo infusion and Sleep Lab services which are expected to produce increased volume
- Execution of *verbal* agreements with BMC's HealthNet and Neighborhood Health Plan to redirect local care to Carney Hospital – these plans are aggressively enrolling local patients into their C-CHIP programs which historically have directed care back to the other facilities
- A stabilization of the market share shift that has occurred between the large and small insurers in the market
- Maintaining current physician base and adding some resources within some specialties

Other issues:

- A study commissioned in 2003 found the "closing costs" associated with Carney to be nearly $50M ($27M in debt, unfunded pension liability, un-remediated environmental issues, likely demolition costs, lost contribution to overhead and net revenue associated with resident slots)
- Current "1950s" IP facility would require a significant recapitalization to be considered marginally competitive by today's standards – not planned nor a prudent use of scarce capital

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Clinical Services Market Assessment Summary

Clinical Service Line	Market Opportunity Assessment					
	SEMC	Good Samaritan	St. Anne's	Carney	Norwood	Holy Family
Overall Verdict	Limited local market for high level programs, recent setbacks and missing program elements = **FAIR/POOR**	Strong market and some existing program elements =**GOOD**	Strong competition has limited opportunity but favorable market = **FAIR**	Uncertain local market and outdated facility = **POOR**	Limited competition (for now) and strong market =**VERY GOOD**	Good market and some existing program elements = **GOOD**
Bone & Joint	Lost cornerstone surgeons - rebuilding strategy unclear, may require JV	Need focus on workshop and physician alignment strategy	Significant level of investment needed to rebuild program	Poor market position and highly outdated facilities a serious detriment to achieving program growth	Good opportunity to grow - focus on workshop and physician alignment strategy	Need focus on workshop and physician alignment strategy
Cardio-vascular Services	Proximity to AMCs and physician dynamics present barriers – along with limited local market growth	New Cath service should fuel growth	Limited opportunity - all but basic medical cardiology is lost to competitor	Offering basic medical capabilities only	Good opportunity to grow the service - new cath service may fuel program	Needs to win angio rights in order to grow program and continue local investment
Oncology	Limited opportunity – local market will not support surgical capabilities and necessary RT investment	Some good elements – need coordination and consolidation as well as investment; new deal/JV for RT in the works	Solid program – only issue is recapture of lost surgical oncology volume in market	Despite recent investments in chemo and PET, market opportunity unclear	Some good elements – need coordination/ consolidation and investment in imaging	Solid program elements - need reinvestment in cancer center and technology
Neuro-sciences	Destination Neurology group but non-existent NS limit program growth opportunity	Good opportunity to build stroke/spine service but requires investment in both physicians and facility	Limited opportunity – lost bidding war for only NS group to competitor	Weak program with recent physician losses – program at risk	Good opportunity but requires investment in both physicians and facility	Solid program but needs continued investment to maintain position

- Common thread is need for significant investment to realize any of the potential for growth

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Option 2: National Catholic System Affiliation

Description: Affiliate with a national Catholic system – transfer reserve powers to a "professional" Catholic hospital manager

Key Issues:

- Two choices – Ascension and Catholic Health East(CHE)
- Both would retain ultimate control over capital allocation, effectively limiting CCHS's ability to attract an "A" team system board
- Future role for Archdiocese unclear – complete transfer of sponsorship may be required; an annual sponsorship fee is possible
- Local boards would be retained and given very clear roles relative to managing local politics and physician relations
- Separate negotiations would need to take place with St. Anne's co-sponsor, which may not choose to remain part of Caritas or join the national Catholic system
- Pros: immediate increased debt capacity, immediate access to highly efficient back office capabilities, large scale IT and quality initiatives, easier access to top talent, CCHS remains fully Catholic, high possibility for annual "sponsorship fee" for Archdiocese
- Cons: No role for a CCHS "A" team board, capital allocation and all other control transferred out of town.
- Verdict re: Risk/Responsibility – TRANFERRED to another Catholic entity

.Open discussion items to be addressed today:

- Catholic system level of interest in CCHC
- Possible terms and affiliation models

Option 2: National Catholic Affiliation, continued

Discussions have been held with the two systems in question, with key findings summarized below

ASCENSION HEALTH

- Headquartered in St. Louis, MO with operations in 20 states including NY, CT, PA, MD and the District of Columbia
- Formally organized in 1999, currently sponsored by six organizations: the Daughters of Charity(4 congregations including former Carney sponsor), the Sisters of St. Joseph of Nazareth and the Sisters of St. Joseph of Carondelet
- 64 acute care hospitals, 6 LTAC facilities, 8 specialty facilities and 9 nursing homes
- FY 06 operating revenues: $11.4B, total assets: $14.9B; Moody's rating is Aa2 – stable outlook
- Very interested in growth
- Decision matrix require strong local board but reserve powers held corporately
- Co-sponsorship of the whole, sponsorship fee, control of future alienations and proceeds negotiable
- Closest hospital is Bridgeport, CT

- Headquartered in Newtown Square, PA with operations in 10 states along the east coast, including MA (Mercy Medical Center in Springfield) and multiple locations in NY
- Formally organized in 1998 , currently sponsored by 15 organizations
- 33 acute care facilities, 4 LTAC facilities, 41 long-term care facilities, 18 assisted living-type facilities, 32 home health/hospice agencies
- FY 05 operating revenues: $4.2B; total assets: $5.2B; Moody's recent upgrade to A1 – stable outlook
- Operates as a system of regional entities
- Decision matrix require strong local board but reserve powers held corporately
- Co-sponsorship by Archdiocese not an option, sponsorship fees, control of future alienations and proceeds are negotiable

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Option 3: CCHC Local Merger or JOA

Description: Affiliate with a local Boston healthcare system – most likely NEMC or BMC.

Key Issues:

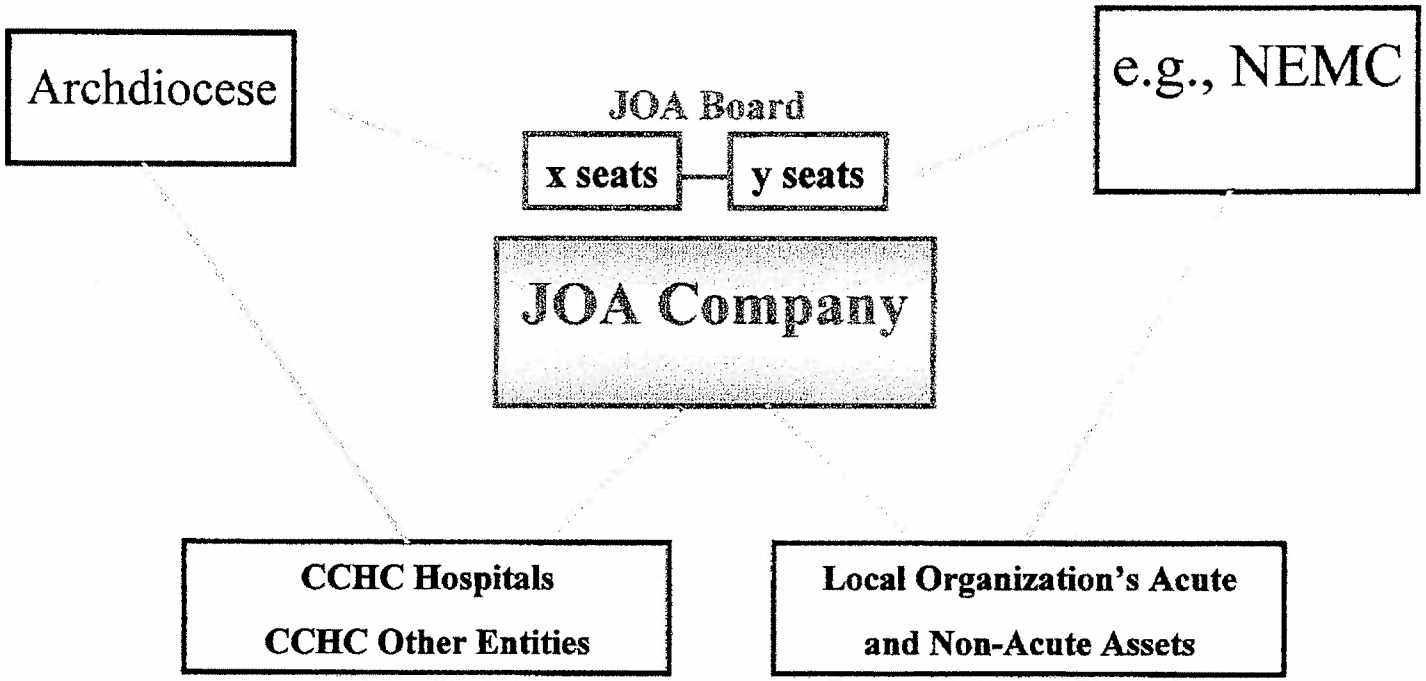
- Retaining Catholicity is obviously important – possible to do this through a Joint Operating Agreement (JOA) between the two entities. Ultimately the Cardinal has the authority to determine what's Catholic and not.
- NEMC makes sense from a historic perspective but is currently in a precarious financial position – two "wrongs" don't make a right especially to Wall Street – not much advantage re: capital
- BMC is very focused around underserved populations – a good fit with CCHS mission except for the religious directives
- Religious directives (stem cell issues) will become an increasingly bigger problem for CCHS
- NEMC would probably end its plans for a suburban hospital with a CCHS affiliation but there would certainly be some rationalization of services, especially between St. E's and NEMC
- St. Anne's – co-sponsor likely to desire an unwinding of Caritas relationship under this scenario
- Pros: likely positive political/media reaction, restored main street credibility, a "known" quantity
- Cons: Likely partners have financial/operational issues of their own, uncertain Wall street reaction, challenging JOA discussion, diluted Catholicity, retained risk/responsibility, difficult and costly to unwind
- Verdict re: Risk/Responsibility – SHARED between CCHS and other entity

.Open discussion items to be addressed today:

- Local system level of interest in CCHC
- Possible terms and affiliation models

Option 3: Outline of a Local JOA

Sample Joint Operating Model for a CCHC – Local Merger



ownership

management

- **Net proceeds from the operating company are returned to the parent organizations and split by an agreed upon methodology**
- **Unwinding a JOA can be costly and difficult**

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Option 4: Sale of CCHC to Taxable Entity

Description: Sell assets of the system to a for-profit hospital system – most likely Vanguard

Key Issues:

- Significant dollar amt. ($120M+) could help Archdiocese – but public sale and $$ gain likely to also attract unwanted attention from the local legal community who has profited at the expense of the Catholic Church in the recent past.
- While there are ways to protect the observance of religious directives - the organization will no longer technically be Catholic health care.
- Local political and media reaction likely to be highly negative but short-lived
- St. Anne's co-sponsor highly likely to reject this option and request a divestiture from CCHC
- Pros: immediate cash, protection of religious directives,
- Cons: Catholicity of health care in the community diluted, likely negative public reaction
- Verdict re: Risk/Responsibility – TRANSFERRED.

Open discussion items to be addressed today:

- For-Profit level of interest in CCHC - Vanguard
- Possible terms

Option 4: Sale of CCHC to Taxable Entity, continued

Discussions have been held with Vanguard, with key findings summarized below

VANGUARD HEALTH SYSTEMS

- Headquartered in Nashville, TN
- Formally organized in 1997, acquired first hospital in 1998; currently owns and operates 16 acute care hospitals in 4 states
- FY 06 total revenue of $2.2B, total assets of $2.6B
- From the website:
  - *Vanguard seeks to convert non-profit multi-hospital systems to investor-owned entities while preserving and enhancing their ability to fulfill their missions.*
  - *The Company's strategy is to develop locally branded, comprehensive healthcare delivery networks in urban markets. Upon acquiring a facility or network of facilities, Vanguard implements strategic and operational improvement initiatives, including expanding services, strengthening relationships with physicians and managed care organizations, recruiting new physicians and upgrading information systems and other capital equipment. These strategies improve quality and network coverage in a cost effective and accessible manner for the communities we serve.*
  - *Vanguard's goal is to support and enhance the non-profit mission of service to these communities. At Vanguard, we believe that all healthcare is local, and all decisions are best made on the local level. Our goal is not to operate our facilities from a centralized corporate office, but to establish a strong management team at the hospital and to establish a strong, local Board of Trustees to provide guidance to the management team.*
- Vanguard owns St. Vincent Hospital in Worchester; St. Vincent CEO John Smithhisler's website message states, " **Saint Vincent Hospital continues its commitment to provide care in the *Catholic tradition* from its new location without regard for race, color, creed or gender."**
- Vanguard interest in CCHC is very high and a transaction could include ALL CCHC hospitals, including SEMC and Carney
- Estimate of net proceeds - $120+ M

Evaluation of Options from the Sponsor's Perspective

At our meeting on October 10, we assigned a high-level judgment of the relative "risk and responsibility" associated with each option. A more thorough evaluation of risk and the associated reward available to the Archdiocese by each option as well as the relative responsibility helps illustrate these paths.

Evaluation Metrics

Risk Factors for the Archdiocese
- Execution
- Scandal
- Capital

Rewards for the Archdiocese
- $ available to the Archdiocese vs. reinvestment in health system
- Success of "Catholic" healthcare in Boston

Each option has a different, relative level of Archdiocesan financial responsibility for preserving/developing the assets of CCHC

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Evaluation of Options from the Sponsor's Perspective, continued

Strategic Option	Risk (high = low score)	Reward (high = high score)	Total Score	Responsibility
Option 1: Go-Forward Strategy	**High – 1** • Challenging execution, high capital need, uncertain local reaction	**Medium – 2** • Little to no $ available to the Archdiocese but Catholicity of system never in question	3	Financial responsibility for the asset remains squarely with the Archdiocese; little short term impact on credibility which increases execution risk
Option 2: New Catholic Sponsor	**Low – 4** • New sponsor responsible for capital and execution; neutral/favorable local reaction	**High – 4** • Catholicity maintained and probability of some sponsorship fee for Archdiocese	8	Financial responsibility for the asset is transferred to the new sponsor; several Catholic systems are very credible on Wall Street and Main Street
Option 3: Local Merger/ JOA	**Med-High – 2** • Challenging execution but local consolidation opportunities, high capital need but shared with another entity	**Low – 1** • Although Cardinal has final word, Catholicity of system will likely be challenged with little to no new $ available to Archdiocese	3	Financial responsibility for operations is shared with partner possibly through new operating company, while responsibility for the CCHC assets remains with the Archdiocese; likely increases Main Street credibility more than Wall Street
Option 4: Sale to For-Profit	**Med-Low– 3** • New owner responsible for execution and capital; likely unfavorable local reaction to change in tax status; state review of use of proceeds	**Medium-High - 3** • Significant new $ available to Archdiocese and Catholic issues negotiable with buyer	6	Financial responsibility for the asset is completely transferred; likely increases Wall Street credibility more so than Main Street.