Department of Health

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June 20, 2024

VIA ELECTRONIC MAIL

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Re: The Hospital Conversions Act Initial Application of The Centurion Foundation, Inc., CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, Inc., CharterCARE Our Lady of Fatima Hospital, Inc., Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC

Dear Attorney Rocha:

Please find attached the Rhode Island Department of Health's Decision on the Hospital Conversions Act Initial Application of The Centurion Foundation, Inc., CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, Inc., CharterCARE Our Lady of Fatima Hospital, Inc., Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC.

Please be advised that any aggrieved Transacting Party may seek judicial review pursuant to section 23-17.14-34 of the Rhode Island General Laws, as amended.

Sincerely,

Jerome M. Larkin, MD
Director, Rhode Island Department of Health

Rhode Island Department of Health

Decision of Approval with Conditions	**Hospital Conversions Act Initial Application of The Centurion Foundation, Inc., CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, Inc.; CharterCARE Our Lady of Fatima Hospital, Inc., Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC (collectively, the "Transacting Parties")**

Jerome Larkin, MD

Director, Rhode Island Department of Health

June 20, 2024

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I. Introduction

This matter came before the Rhode Island Department of Health ("RIDOH") on July 12, 2023, with the filing of a Hospital Conversions Act Initial Application ("HCA Application"). This Decision is issued pursuant to RIDOH's statutory authority under the Hospital Conversions Act ("HCA"), R.I. Gen. Laws § 23-17.14-1 *et seq*.

The HCA Application, as deemed complete by RIDOH and the Rhode Island Office of the Attorney General ("RIAG") on December 14, 2023, is available at the following link: HCA Application

This matter involves the sale of two Rhode Island hospitals and their related affiliates. Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center ("RWMC") is currently a for-profit licensed acute care hospital (license number HOSP00133) located in Providence, Rhode Island. Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital ("OLF") is currently a for-profit licensed acute care hospital (license number HOSP00132) located in North Providence, Rhode Island. RWMC, OLF, and their affiliates are owned by Prospect Medical Holdings, Inc. ("PMH"), a California-based for-profit healthcare company. The Centurion Foundation, Inc. ("Centurion") is a Georgia-based non-profit corporation formed in 1996 that aids in the development, acquisition, and financing of non-profit healthcare projects. Centurion has formed CharterCARE Health of Rhode Island, Inc. which will be the parent of CharterCARE Roger Williams Medical Center, Inc. and CharterCARE Our Lady of Fatima Hospital, Inc. and its affiliates post-acquisition. Centurion is the sole member of CharterCARE Health of Rhode Island, Inc., which is the sole member of CharterCARE Roger Williams Medical Center, Inc. and CharterCARE Our Lady of Fatima Hospital, Inc. The purchase price for the transaction is $160 million, subject to deductions outlined in the Asset Purchase Agreement.

Extensive materials were considered in RIDOH's review, including application documents; materials provided by PYA, P.C. ("PYA"), a consulting group engaged by RIDOH, including a report titled *Summary Report on Hospital Conversion Act Application Involving Prospect CharterCARE* ("PYA's Report"), attached hereto as Appendix A; materials provided by Dr. Patrick Romano, a consultant engaged by RIDOH, including a report titled *Review of the Proposed Conversion of Roger Williams Medical Center, Our Lady of Fatima Hospital, and Their Affiliates by the Centurion Foundation, Inc.: Implications for Health Care Quality, Access, and Utilization*, attached hereto as Appendix B ("Quality Report"); public comments supporting and objecting to the HCA Application, both written and provided during public meetings; transcripts of two public meetings held jointly by RIDOH and RIAG; and transcripts from the Statements Under Oath ("SUO") that were conducted jointly by RIDOH and RIAG.

RIDOH carefully applied the relevant criteria in rendering this Decision, including character, competence, commitment, continued access to affordable care for traditionally underserved

populations, retention of the workforce, and access to essential medical services needed to provide safe and adequate treatment, amongst other criteria. Additional consideration was given to RIDOH's leading priorities of addressing social and environmental determinants of health, eliminating health disparities, promoting health equity, and ensuring access to quality health services for all Rhode Islanders, including our vulnerable populations. RIDOH further reflected on its strategic priorities and guiding principles as a framework for examining applications under review for consideration in making decisions regarding such applications.

II. Hospital Conversion Application Travel

On May 26, 2023, the Transacting Parties submitted written materials to RIDOH and RIAG. However, the Transacting Parties were notified on May 30, 2023, that the materials did not constitute an Initial Application pursuant to R.I. Gen. Laws § 23-17.14-6 because they did not consist of the current, required version of the application as prescribed by RIDOH and RIAG.

Thereafter, the Transacting Parties submitted written materials to RIDOH and RIAG on June 30, 2023. On July 7, 2023, RIDOH and RIAG notified the Transacting Parties that the submission did not meet the requirements because the questions in the submission did not match the original questions in the application form that the Transacting Parties were provided and did not include the appropriate "Certification" pages.

On July 12, 2023, the Transacting Parties submitted their HCA Initial Application in accordance with the HCA. On August 11, 2023, RIDOH and RIAG deemed the HCA Application incomplete and issued deficiencies, outlining outstanding information required for the application to be deemed complete. Pursuant to R.I. Gen. Laws. § 23-17.17-7(b), a resubmitted HCA Application was due by September 26, 2023. The Transacting Parties subsequently requested an extension through October 26, 2023, which was granted. An additional extension was requested by the Transacting Parties on October 25, 2023, and granted through November 14, 2023. The HCA Application was resubmitted on November 14, 2023.

On December 14, 2023, RIDOH and RIAG deemed the HCA Application complete, with the review commencing on December 15, 2023. On that same day, RIDOH and RIAG issued a joint notice that all persons wishing to comment on the HCA Application submit their comments to RIDOH and RIAG by February 29, 2024, when practicable. The date to submit public comment was later extended to March 29, 2024.

All public notices related to the HCA Application can be accessed via the following links:

Public Notice of Centurion-Prospect HCA Application and Public Informational Meetings

Amended Public Notice of Centurion-Prospect HCA Application and Public Informational Meetings

Second Amended Public Notice of Centurion-Prospect HCA Application and Public Informational Meetings

III. Transacting Parties

This HCA Application involves the following licensed hospitals:

RWMC is a licensed acute care hospital (license no. HOS00133), for 220 beds, in Providence. RWMC is an academic medical center affiliated with Boston University School of Medicine.

OLF is a licensed acute care hospital (license no. HOS00132), for 312 beds, in North Providence.

The parties (collectively the "Transacting Parties") to the HCA Application are identified below:

Centurion is an Atlanta-based, non-profit corporation formed in 1996 that provides services, programs and activities that center on charitable foundation leases to further the mission of other non-profits. As proposed, Centurion would become the sole corporate member of CharterCARE Health of Rhode Island, Inc.

CharterCARE Health of Rhode Island, Inc. ("CharterCARE Health of Rhode Island") is a newly formed non-profit corporation whose sole member is Centurion. As proposed, CharterCARE Health of Rhode Island would be responsible for the operation of the healthcare system as a whole. As proposed, CharterCARE Health of Rhode Island would be the sole corporate member of CharterCARE Roger Williams Medical Center, Inc. and CharterCARE Our Lady of Fatima Hospital, Inc.

CharterCARE Roger Williams Medical Center, Inc. ("CharterCARE RWMC") is a newly formed non-profit corporation, that as proposed, would become the owner, operator, and licensee of RWMC.

CharterCARE Our Lady of Fatima Hospital, Inc. ("CharterCARE OLF") is a newly formed non-profit corporation, that as proposed, would become the owner, operator, and licensee of OLF.

CharterCARE Health of Rhode Island Foundation, Inc. is a charitable nonprofit corporation formed for the purposes of managing, raising, and disbursing funds and donations for the benefit of charitable, tax-exempt purposes.[1]

Chamber Inc. ("Chamber") is a Delaware corporation owned by Samuel Lee and the David Topper Family Trust. Chamber is the sole owner of Ivy Holdings Inc., which is the sole owner of Ivy Intermediate Holdings, Inc., which is the sole owner of PMH.

[1] While CharterCARE Health of Rhode Island Foundation, Inc. is not a Transacting Party to the Proposed Transaction, it is a related affiliate.

Ivy Holdings Inc. ("IH") is an investor-owned holding company. IH wholly owns Ivy Intermediate Holdings, Inc.

Ivy Intermediate Holdings, Inc. ("IIH") wholly owns PMH.

PMH is a California-based healthcare company that owns and operates hospitals and affiliated medical groups in California, Connecticut, Pennsylvania, and Rhode Island. PMH wholly owns Prospect East Holdings, Inc.

Prospect East Holdings, Inc. ("PEH") is a holding company that does not provide services and is wholly owned by PMH.

Prospect CharterCARE, LLC ("PCC") is a Rhode Island limited liability company and is the sole member of both RWMC and OLF.

OLF is a licensed acute care hospital (license no. HOS00132).

RWMC is a licensed acute care hospital (license no. HOS00133).

Other Defined Terms

The New CharterCARE System ("New CharterCARE System") collectively refers to the post-closing entities which includes CharterCARE Health of Rhode Island, CharterCARE RWMC, CharterCARE OLF, CharterCARE Blackstone Surgery, LLC, CharterCARE Physicians, LLC, CharterCARE Health of Rhode Island Foundation, Inc., CharterCARE Associates in Primary Medicine, LLC, CharterCARE Home Health and Hospice, LLC, and CharterCARE Roger Williams Medical Center, Inc. d/b/a CharterCARE Sleep Disorders Center.

The Existing Hospitals ("Existing Hospitals") collectively refers to RWMC and OLF.

The New Hospitals ("New Hospitals") collectively refers to CharterCARE RWMC and CharterCARE OLF.

The Prospect Transacting Parties ("Prospect Transacting Parties") collectively refers to Chamber, IH, IIH, PMH, PEH, PCC, RWMC, and OLF.

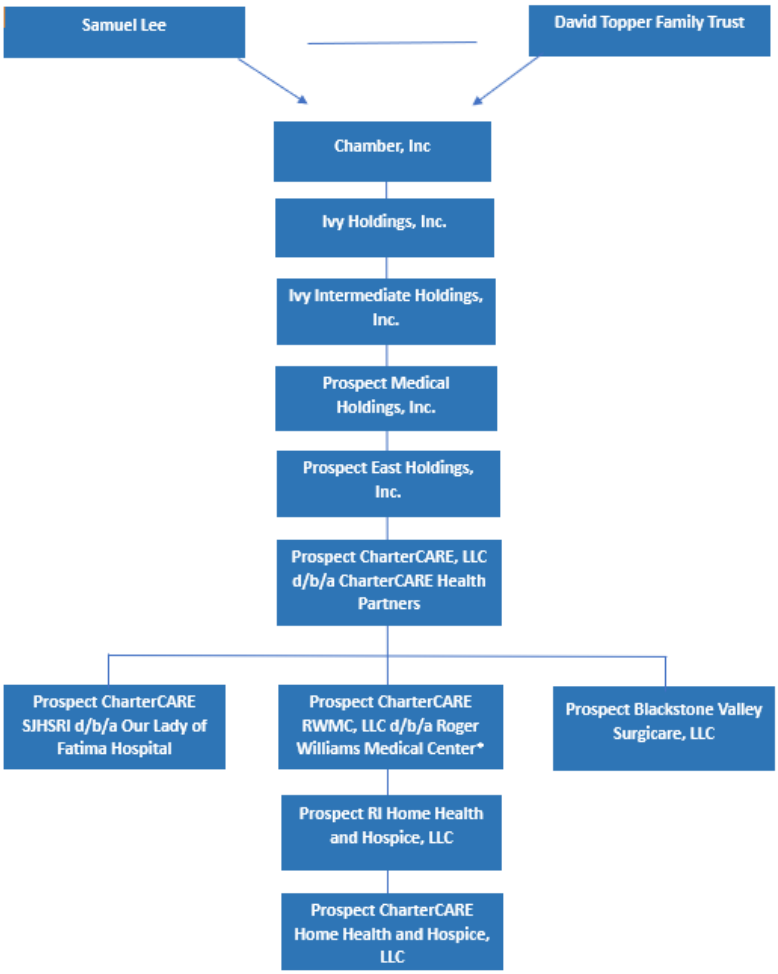
The Centurion Transacting Parties ("Centurion Transacting Parties") collectively refers to Centurion, CharterCARE Health of Rhode Island, CharterCARE RWMC, and CharterCARE OLF.

IV. Description of the Proposed Transaction

The structure of the transaction outlined in the HCA Application is a sale of substantially all of the assets of PCC, a for-profit entity, to Centurion, a non-profit entity, pursuant to the parties' Asset Purchase Agreement ("APA") dated November 18, 2022, as amended on April 18, 2023, and further amended on November 7, 2023 (the "Proposed Transaction"). Centurion is the ultimate corporate parent to the newly formed non-profit entities that Centurion states will hold the assets. As described above, the newly formed entities include CharterCARE Health of Rhode Island, CharterCARE RWMC, and CharterCARE OLF. It is intended that CharterCARE RWMC and CharterCARE OLF, respectively, will own and operate the Existing Hospitals. While the New CharterCARE System is not a party to the APA, Centurion has asserted that it will assign its rights in the APA to the New CharterCARE System prior to close of the Proposed Transaction.

A copy of the pre- and post-transaction organizational charts are below, Exhibit 1 and Exhibit 2, respectively.

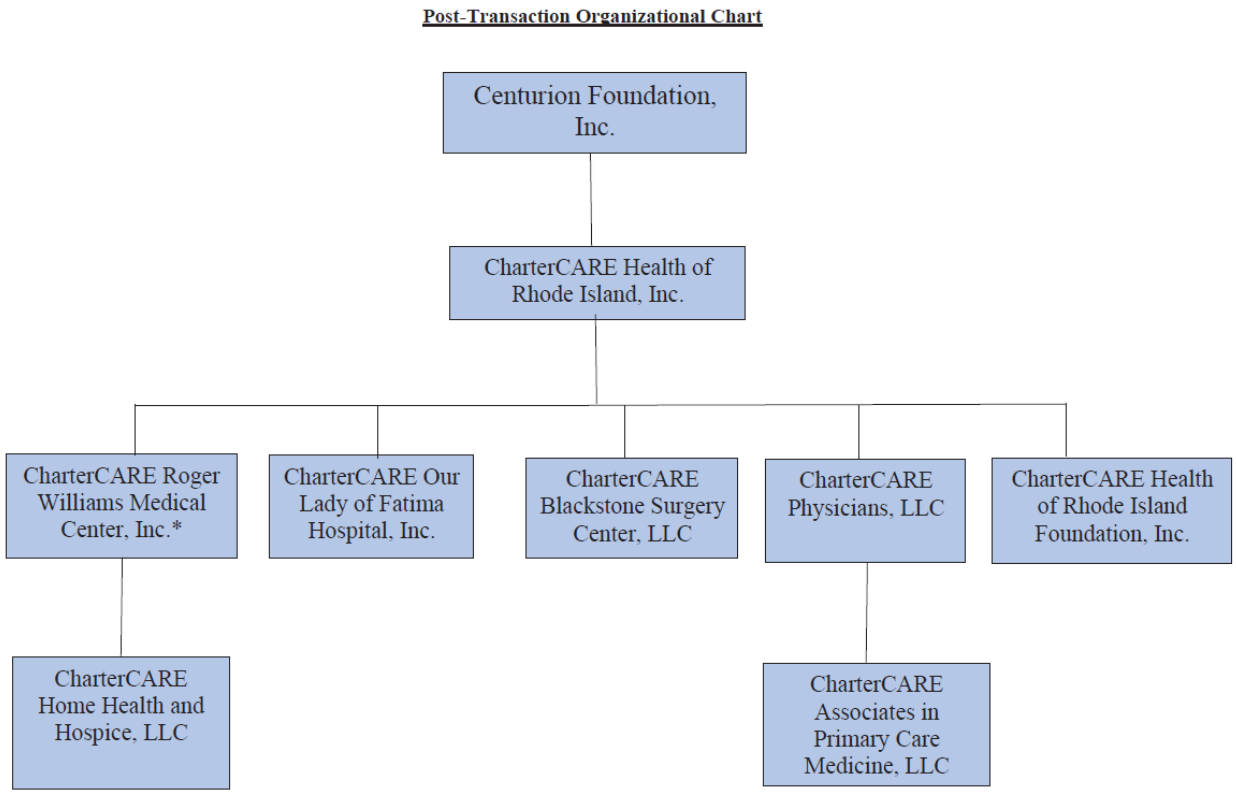
Exhibit 1: Pre-Transaction Structure[2]



*CharterCARE Sleep Disorders Center, OACF with license number ACF01620, is included as part of this legal entity

[2] This organizational chart was created based on information provided in the HCA Application, as well as RIDOH's prior HCA decision. See HCA Application, Response to Question 65; see also RIDOH's June 1, 2021 Hospital Conversions Act Decision.

Exhibit 2: Post-Transaction Proposed Structure[3]



*CharterCARE Sleep Disorders Center, OACF with license number ACF01620, is included as part of this legal entity.

Following the close of the Proposed Transaction, the Existing Hospitals will be returned to non-profit status, which the Transacting Parties assert will result in a "more sustainable level of performance." The New CharterCARE System will be governed by a local board of directors and a local management team. While Centurion is the ultimate corporate parent, it will not have a day-to-day role in operating the New Hospitals. Instead, Centurion refers to itself as a "sponsor" of the New CharterCARE System, where it will "provide guidance and expertise" as necessary. After closing, the New CharterCARE System will be governed by a board of directors including local community members and Centurion representatives. The New CharterCARE System will be led by the existing PCC Chief Executive Officer ("CEO"), Jeffrey Liebman, and other members of the current management team.[4]

[3] See HCA Application, Response to Question 65.
[4] The management team includes:
A. Jeffrey H. Liebman, Chief Executive Officer.

Pursuant to the APA, the purchase price was agreed to be the fair market value of the assets, which was determined to be in the range of $139.0 million to $161.0 million. Subsequent to the valuation, the Transacting Parties agreed to a purchase price of $160.0 million. The APA was later amended to reduce the purchase price to $80.0 million, which has been described by the Transacting Parties as the net purchase price. It is anticipated that the New CharterCARE System will finance the $160 million value, plus closing costs, and place $80 million of cash on the New CharterCARE System's balance sheet at closing. The total net debt associated with the Proposed Transaction is approximately $192 million, comprised of taxable and tax-exempt bonds, as more fully described in the below table:[5]

Sources and Uses ($000s)

	2024A (Taxable)	2024B (Tax-Exempt)	Aggregate
Sources			
New Money Par	$40,985	$92,410	$133,395
Net New Money Original Premium (Discount)	$-	($1,467)	($1,467)
Assumed PACE Loan	$-	$-	$60,165
Total Sources	**$40,985**	**$90,943**	**$192,093**
Uses			
Project Fund Deposits:			
Fair Market Value Debt Allocation	**$34,835**	**$80,000**	**$114,835**
Other Fund Deposits:			
DSRF	$4,099	$9,094	$13,193
Delivery Date Expenses:			
Cost of Issuance	$2,049	$1,848	$3,897
Other Uses of Funds:			
Additional Proceeds	$2	$0	$3
Assumed PACE Loan	$-	$-	$60,165
Total Uses	**$40,985**	**$90,943**	**$192,093**

Cash Proceeds Breakdown ($000s)

Description	Amount
Acquisition Fair Market Value	$160,000
Assumed PACE Loan	($60,165)
PACE Escrow	$15,000
Net Fair Market Value Debt Allocation	**$114,835**

Step 1: Taxable Use Breakdown ($000s)

Description	Amount
Taxable Debt Requirement ($80MM Cash)	$80,000
Assumed PACE Loan	($60,165)
PACE Escrow	$15,000
Net Taxable Bond Proceeds Allocation	**$34,835**

Step 2: Tax-Exempt Use Breakdown ($000s)

Description	Amount
Net Fair Market Value Debt Allocation	$114,835
Net Taxable Bond Proceeds Allocation	$34,835
Tax-Exempt Bond Proceeds Allocation	**$80,000**

As proposed, the New CharterCARE System (as opposed to Centurion) will be responsible for the financial obligations associated with the Proposed Transaction. As proposed, Centurion has stated that they will not provide financial support to the New CharterCARE System for capital projects

B. Amanda Cox, Vice President and Chief Information Officer.
C. Cherry Clavette Krys, Vice President of Compliance.
D. Dan Ison, Vice President of Financial Services.
E. Donna Rubinate, Chief Operating Officer.
F. Jeffrey Bechen, Vice President of Revenue Cycle.
G. Lynn Leahey, Chief Nursing Officer.
H. Maria Zammitti, Vice President of Hospital and Managed Care Contracting.
I. R. Otis Brown, Vice President of Marketing and Government Relations.
J. Rebecca Brown, MD, Executive Physician of Clinical Integration.
K. Steven Salisbury, Vice President of Accounts Payable and Payroll.
L. Susan Benfeito Beliveau, Vice President of Quality, Risk and Behavioral Health.
M. Tracey Crandall, Vice President of Human Resources.

See HCA Application, Response to Question 65.
[5] See HCA Application, Response to Question 65.

or operating losses. Closing of the Proposed Transaction is expected to take place three (3) to six (6) months after regulatory approval.

The Proposed Transaction contemplates implementation of improvement initiatives ("Improvement Initiatives") and execution of an integration plan. The Transacting Parties assert that these Improvement Initiatives will result in financial improvements of $41 million during the first year after the Proposed Transaction.[6] The Centurion Transacting Parties state they have no plans for reduction of existing services and/or facilities as a result of the Proposed Transaction, and do not anticipate staffing reductions as part of implementing the plan to reduce expenses over the next two years. Further, they have no plans for the development of new services and/or facilities.

V. Procedural History

In 2008 and 2009, the systems of St. Joseph Health Services of Rhode Island and Roger Williams Medical Center were losing in excess of $8 million dollars a year. In 2009, RIDOH approved the affiliation of St. Joseph Health Services of Rhode Island, Roger Williams Medical Center, Roger Williams Hospital, and CharterCARE Health Partners ("CCHP"). The affiliation of St. Joseph Health Services of Rhode Island, which provided acute care services at its Our Lady of Fatima Hospital division, Roger Williams Medical Center, and Roger Williams Hospital, resulted in the creation of a new health care system, CCHP. CCHP was a nonprofit corporation formed for the purposes of the affiliation. The affiliation aimed to enhance the respective charitable purposes and missions of the hospitals and to better serve the health care needs of the hospitals' respective communities, while also preserving the Catholicity of St. Joseph Health Services of Rhode Island and enhancing Roger Williams Hospital's historic mission of medical research and education. Difficulties were faced by the hospitals when operated independently. The affiliation strove to remedy the operational losses experienced by the hospitals through combining the two hospital systems and expanding services to the communities served by the hospitals. Following the 2009 HCA approval, Our Lady of Fatima Hospital and Roger Williams Hospital, while affiliated, remained two separately licensed acute care hospitals.

While there were noted improvements in operations after the creation of CCHP and the affiliation of the two separate systems, CCHP continued to experience unsustainable losses. Hence, a more viable structure was needed, which ultimately led to the 2014 HCA Decision, whereby PMH came to Rhode Island and acquired the hospitals.

In 2014, RIDOH approved the application of PMH and CCHP whereby PMH purchased an 85% interest in the existing hospitals and CCHP retained a 15% interest in the existing hospitals. The purchase price was $45 million, with a $50 million capital commitment within 4 years of closing,

[6] The Improvement Initiatives are further described in the HCA Application, Response to Question 1 and the PYA Report. See also HCA Application, Response to Question 65, Transition Plan, Tab 1, Exhibit A of the CEC Application, dated April 18, 2024.

and a $10 million per year commitment for routine capital investments. This transaction resulted in the hospitals converting from non-profit to for-profit status. PCC, the newly formed entity, was classified as a for-profit entity and operated the health care system that included RWMC and OLF.

PMH was wholly owned by IIH, which was wholly owned by IH. IH was owned by a combination of two private equity investment limited partnerships: Green Equity Investors V, L.P. (44.48%) and Green Equity Investors Side V, L.P. (13.34%) (collectively, "Leonard Green") and Samuel Lee (19.51%) and David Topper through the David & Alexa Topper Family Trust (14.45%). Other management owned a small minority of shares, each with less than 10% interest in IH.

In 2019, Chamber, a newly formed entity, and IH, the parent of PMH, filed an HCA application and Change in Effective Control ("CEC") application seeking approval of the buyout of IH's majority owner Green Equity Investors V, L.P. and Green Equity Investors Side V, L.P. The proposed transaction involved Leonard Green exiting the company, with Samuel Lee and the David Topper Family Trust becoming the sole shareholders of Chamber (66.7% and 33.33% respectively). In 2021, RIDOH approved the application of PMH for this change in ownership. After the transaction, Green Equity Investors V, L.P. and Green Equity Investors Side V, L.P. and other minority management shareholders no longer retained interest in IH, the parent company of PMH. The purchase price was $11,940,992 with no debt associated with the proposed payment. The newly formed entity, Chamber, became the parent company and remains the for-profit entity that owns the health care system that includes RWMC and OLF. It is reported in the HCA Application that Samuel Lee and the David & Alexa Topper Family Trust now each own 50% interest in Chamber. It remains unclear when this change occurred.

VI. HCA Authority and Statutory Criteria

Since 1997, certain transfers in ownership, assets, membership interest, authority, or control of a hospital are subject to the HCA, R. I. Gen. Laws § 23-17.14-1, *et seq*..

§ 23-17.14-4(6) of the HCA defines a "Conversion" as:

"*any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, holds or owns, in the aggregate, twenty percent (20%) or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital."*

The Proposed Transaction satisfies the definition of a conversion under the HCA and is therefore subject to the prior review and approval of RIDOH and RIAG. Pursuant to R.I. Gen. Laws § 23-17.14 *et seq*., the review of the HCA Application is conducted by RIDOH and RIAG concurrently. Separate statutory review criteria are established under the HCA for RIDOH and RIAG.

RIDOH reviews HCA applications in consideration of the following nine statutory criteria:

In reviewing an application for a conversion involving hospitals in which one or more of the transacting parties is a for-profit corporation, the department of health shall consider the following criteria pursuant to R.I. Gen. Laws § 23-17.14-8:

> **(1)** Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties, are satisfactory;
>
> **(2)** Whether sufficient safeguards are included to assure the affected community continued access to affordable care;
>
> **(3)** Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;
>
> **(4)** Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;
>
> **(5)** Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;
>
> **(6)** Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;
>
> **(7)** Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access, and balanced healthcare delivery to the residents of the state; and
>
> **(8)** Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval for any previous conversion pursuant to an application submitted under § 23-17.14-6.

In addition, under R.I. Gen. Laws § 23-17.14-28(a), the Director shall also consider:

> **(9)** market issues, including market share, especially as they affect quality, access, and affordability of services.

Importantly, none of the criterion are considered in isolation. RIDOH informs its review through the lens of the purpose of the HCA including to "[a]ssure the viability of a safe, accessible and

affordable healthcare system that is available to all of the citizens of the state[.]" R.I. Gen. Laws § 23-17.14-3(1).

VII. Description of RIDOH's Review Process Under the HCA (the "Record")

The Record RIDOH reviewed and considered in rendering this Decision includes the HCA Application, supplemental responses, and information provided throughout the review, written comments received from interested parties, comments provided at public meetings, transcripts from SUO, information gathered at a site visit to RWMC and OLF, consultants' observations and reports, and relevant publicly available information.

a. Application and Other Documents Supplied by Transacting Parties

The application form consists of sixty-six (66) questions and requests for information and six (6) required appendices, including, but not limited to:

- a detailed summary of the proposed conversion;
- a description of the governance structure of the hospital post-conversion, including a description of how members of any board of directors, trustees, or similar type group will be chosen;
- the planning process and resulting integration plan;
- consultant reports concerning the affiliation, including due diligence reports;
- agreements, contracts, and conflict of interest policies and statements related to the proposed affiliation;
- recent or pending citations, violations, enforcement actions, charges, investigations, or litigation;
- description of consolidated healthcare and administrative services;
- plans relative to staffing levels of all categories of employees following the implementation of the proposed conversion;
- plans for all departments or services that will be eliminated or significantly reduced at the hospital following the implementation of the proposed conversion;
- description of the plan as to how the Transacting Parties and their affiliates will provide community benefits and charity care;
- past financial information for each Transacting Party and future financial projections under the proposed affiliation; and
- impact of the proposed affiliation on the hospital's market share and on the cost of healthcare.

Question 66, Appendix F of the HCA Application requires the transacting parties to answer relevant additional questions specific to their proposed transaction. In this case, RIDOH and RIAG issued one hundred and eleven (111) additional questions.

Additionally, RIDOH considered responses to the two hundred and thirty-five (235) supplemental questions issued by RIDOH during the review, as well as information and documentation provided in response to RIAG's supplemental questions.

b. Investigations, Other Testimony, and Site Visits

RIDOH, in conjunction with RIAG, conducted several SUO to obtain information to assist with their review and decisions. SUO were taken of the following individuals:

Centurion

1. Benjamin M. Mingle, President ("Mingle")

PCC/New CharterCARE System

2. Jeffrey Liebman, CEO/proposed CEO ("Liebman")

PCC

3. Cecilia Arriera, Interim Chief Financial Officer ("CFO")
4. Daniel Ison, Vice President of Finance Operations

PMH

5. George Pillari, Corporate Chief of Integration and Operations Improvement
6. Alfredo Sabillo, CFO

H2C Securities, Inc.

7. William B. Hanlon, III, Managing Director

Barclays Capital, Inc.

8. Joseph Hegner, Managing Director

United Nurses and Allied Professionals ("UNAP")

9. Christopher Callaci, General Counsel ("Callaci")

The public transcripts of the interviews for SUO and related confidentiality determinations made by RIAG, may be accessed in the following link:[7]

[7] Please note this is a live link and as confidentiality determinations are made by RIAG in accordance with R.I. Gen. Laws §§ 23-17.14-6(c) and 23-17.14-32, the documents will be updated accordingly.

Transcript of Interviews for SUO and Related RIAG's Confidentiality Determinations

Additionally, RIDOH staff and consultants conducted site visits at RWMC and OLF.

c. Public Process

Throughout the review of the Proposed Transaction, RIDOH gathered input from the communities and populations affected by the Proposed Transaction through public meetings and public comment. Additionally, RIDOH provided information to the public about the process and the status of review.

i. Public Record

The HCA contemplates that RIDOH and RIAG maintain both a public and a confidential record. Under R.I. Gen. Laws § 23-17.14-32, RIAG maintains jurisdiction over the determination of the confidentiality and propriety of documents submitted by the Transacting Parties as part of the HCA application review. When available and as confidentiality determinations are made, RIDOH provides the publicly available information on its website.

ii. Public Meeting and Public Comment

The Record also includes written public comments and comments provided at public meetings. RIDOH and RIAG jointly held two hybrid (in-person and virtual) public informational meetings to provide the opportunity for public comment on the HCA Application. Jointly, RIDOH and RIAG's public informational meetings were held on March 19, 2024 and March 26, 2024. At the beginning of both meetings, Liebman and Mingle presented a summary of the Proposed Transaction.

Both meetings were well attended, with nearly seventy (70) individuals providing public comment during the course of the two meetings. Additionally, RIDOH received one hundred and five (105) written public comments.

The transcripts, video recordings and presentations from these joint public meetings is available at the following link: RIDOH/RIAG Public Meetings, March 19 and 26, 2024

All written comments that were received related to the HCA Application may be accessed via the following link: Written Public Comments

d. Consulting Services

Pursuant to the provisions of the HCA, R.I. Gen. Laws § 23-17.14-13, RIDOH may engage experts and/or consultants at the Transacting Parties' expense in the review of a hospital conversion application. RIDOH retained the following consultants to assist with this review:

- PYA,, Independent Financial Consultant Firm
- Jessica Rider, Esq., Jessica Rider Law, LLC, Legal Consultant
- Gerry Goulet, Esq., Health Policy Analytics, LLC, Legal Consultant
- Loreen Angell, Healthcare Consultant
- Alaina Phillippi, MHA, Healthcare Consultant
- Dara Chadwick, Communications Consultant
- Patrick S. Romano, MD, MPH, and team, Quality Consultants
- James P. Carris, CPA, Independent Financial Consultant

e. Change in Effective Control Review

This transaction also requires approval pursuant to Chapter 23-17 of the Rhode Island General Laws, as amended, entitled "Licensing of Health Care Facilities." This process is known as a CEC and requires prior review by the Health Services Council and approval by RIDOH. The CEC review is a public process that can take up to 90 days after initiation of review. On May 26, 2023, RIDOH received the first submission of the CEC applications for PCC's licensed health care facilities. This submission contained four (4) CEC applications pertaining to the following entities: CharterCARE RWMC, CharterCARE OLF, CharterCARE Blackstone Surgery Center, LLC, and CharterCARE Home Health and Hospice, LLC (collectively, the "CEC Applications"[8]). On June 30, 2023, RIDOH then received new copies of the CEC Applications, as changes were made by the parties to Appendix A in the CharterCARE RWMC and CharterCARE OLF CEC Applications and to the signature pages in all CEC Applications. On December 11, 2023, the CEC Applications were resubmitted by the parties as a result of updates made to the HCA Application to exclude references to a consulting company that was no longer a part of the Proposed Transaction.

Upon review of the resubmitted CEC Applications dated December 11, 2023, RIDOH initiated a meeting with the applicant and its representatives to discuss its concerns that were identified in the CEC Applications. The meeting took place on February 12, 2024, and on February 28, 2024, a letter was issued to Centurion in follow-up to the meeting that outlined these areas of concern. Areas of concern described in this letter include the following:

> "*1. As contained in Centurion's CEC Applications, Centurion's experience in the healthcare industry involves only real estate-based transactions; Centurion has no experience with hospital operations.*

[8] The term "CEC Applications" includes the four (4) initially filed CEC applications, as well as the fifth CEC application described below.

Therefore, RIDOH notes that Centurion has yet to demonstrate competency in operating hospitals and other health care facilities.

2. Centurion's CEC Applications lack substantive information to demonstrate how the existing hospitals will transition their operations into a stand-alone, self-sustaining healthcare system.

Therefore, RIDOH notes that Centurion has yet to establish conditions to assure the provision of viable, safe, and adequate healthcare services at the hospitals.

3. Centurion's CEC Applications indicate that Centurion is not committed to funding any capital projects or operational losses for the health care facilities.

Therefore, RIDOH notes that Centurion has yet to demonstrate its commitment to provide any financial backing to the newly formed healthcare system that would assure financial improvement and ongoing sustainability.

4. Centurion's CEC Applications provide that Centurion may place the responsibility and burden of assuming all debt associated with financing the transaction onto the newly formed healthcare system.

Therefore, RIDOH notes that Centurion has not demonstrated commitment to taking ownership of the health care facilities.

5. Centurion's CEC Applications indicate that Centurion's role is limited to arranging financing ***only after*** *receiving regulatory approval.*

Therefore, RIDOH notes that Centurion's lack of timely financing raises concern regarding the successful completion of the overall transaction."

On March 8, 2024, RIDOH issued a deficiency letter to Centurion that identified information necessary to determine completeness. On April 18, 2024, RIDOH received five (5) CEC applications responsive to the March 8, 2024, deficiency letter. This submission included a CEC application for the separately licensed CharterCARE Roger Williams Medical Center, Inc. d/b/a CharterCARE Sleep Disorder Center as required, in addition to the four (4) CEC applications for the aforementioned licensed health care facilities. On May 31, 2024, RIDOH issued a second deficiency letter to Centurion. RIDOH currently awaits receipt of resubmitted applications in response to the deficiency letter to determine completeness and initiate review.

VIII. Discussion of Statutory Criteria

Careful and thorough consideration was given to all information available in the record, including issues raised by all concerned parties. RIDOH's undertaking and commitment are to apply the HCA elements statutorily outlined as the basis of RIDOH's Decision.

a. Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties are satisfactory.

This criterion is critical and all encompassing. In assessing this criterion, RIDOH considers whether the transacting parties deliver patient care in a manner that merits the public trust, that the transacting parties' methods of delivering patient care do not jeopardize the health, safety and well-being of the patients they serve, and that there is no pattern of conduct, behavior, or inaction of the transacting parties that impedes the health, safety, and well-being of their patients.

"*Character*" of the transacting parties may be demonstrated by their corporate integrity and transparency of decision-making. "*Commitment*" refers to the transacting parties' dedication to the communities they are serving. "*Competence"* may be demonstrated by the transacting parties' ability to own and operate hospitals with the requisite experience and support. "*Standing in the community"* may be demonstrated by meeting the commitments and obligations to the community and demonstrating compliance with all regulatory bodies.

Centurion was formed as a non-profit in 1996 and claims a mission of increasing access to, and lowering costs of, healthcare. According to Centurion, this has largely been achieved through development, acquisition, and financing of healthcare facilities. Since 1996, Centurion has completed more than 20 transactions, financing 31 facilities nationwide, totaling approximately $1 billion. Under this model, Centurion consults and collaborates with charitable institutions to advance their charitable purposes. The HCA Application includes select projects that Centurion has completed. Notably, none of Centurion's projects to date include owning and operating hospitals. In fact, this transaction would be Centurion's first experience with owning and operating hospitals. Likewise, none of Centurion's principals—the only three employees of the entity—have direct experience with owning and operating acute care hospitals. This is a unique transaction since Centurion does not own or operate any licensed entities. As a result, RIDOH is unable to assess Centurion against the typical metrics, such as standing with the following groups and agencies:

- state and federal legal systems;
- licensing and certifying agencies;
- The Joint Commission ("TJC") and other accrediting organizations;
- medical staff;
- patients and family members; and

- community members.

With that said, Centurion states it has been a tax-exempt entity since 1996 and has never received any audits, inquiries, or adverse determinations with respect to its 501(c)(3) status. Additionally, Centurion represented that it has no current or impending litigation against it or its affiliates. Finally, testimony received during the SUO indicates a commitment and willingness to the local community and keeping these hospitals open and operational.[9]

Initially, Centurion planned to rely on the expertise of an outside consultant, QHR Health, LLC d/b/a Ovation Healthcare ("Ovation"), to provide shared services and assist with the implementation of the improvement initiatives for the New CharterCARE System. In Fall 2023, Centurion made the decision to move forward with the Proposed Transaction without Ovation, instead relying on the local management team to run the day-to-day operations and decision-making. According to Centurion, the existing management team has sufficient expertise to mitigate risk and stabilize the New Hospitals now and carry the system into a self-sustaining model.

The New CharterCARE System will be led by Liebman, the current CEO of PCC, along with the current management team, nearly all of whom have agreed to continue in their respective roles post-closing. Liebman has been with PCC since 2018. Many other members of senior management have held their respective positions for three or more years (with some much longer). It was evident during the hospital site visits that many of these individuals are dedicated and committed to these hospitals despite the challenges they have faced in recent years. There is no doubt the management team has experience in their respective fields. However, it is unclear whether this set of individuals have the requisite expertise to turnaround a struggling health care system to become an independent self-sustaining system.

The Existing Hospitals have a long history of providing vital services to the community such as emergency medicine, behavioral health, cancer care, bariatric care, and elder care. RWMC has the state's only bone marrow transplant program[10] and Level IV Alcohol & Drug Detoxification Program. In addition to the management team mentioned above, RIDOH heard from many dedicated clinical, administrative and other staff through public comments, public meetings, and during site visits. RWMC is an academic medical center affiliated with Boston University School of Medicine. PCC management represented that this affiliation continues to be successful, with more than fifty (50) postgraduate residents and fellows, as well as several medical students in the program.

Based on the information available to RIDOH, it did not find any evidence related to Centurion's character, commitment, competence and standing in the community that would warrant a finding that this criterion was not satisfied. The concerns identified herein have informed the Conditions which RIDOH imposes in this Decision. As part of its conditions, RIDOH requires Centurion to

[9] See generally Mingle SUO I, May 10, 2021.
[10] Rhode Island Hospital ("RIH"), located in Providence, Rhode Island, received a Certificate of Need on September 7, 2022 for an autologous stem cell transplant program. RIH is currently seeking accreditation for its program.

cover operating expenses of the New CharterCARE System and to appoint a Chief Restructuring Officer ("CRO") to bring the New CharterCARE System to a financially stable position.

PMH has been the ultimate owner of PCC for nearly a decade. During that time, PMH has funded operations and certain capital improvements that have been made to the system. With that said, in recent years, the financial position of PMH nationally and in Rhode Island has become precarious. See PYA Report. It is clear PMH intends to exit Rhode Island and its other East Coast operations, as evidenced by its attempts to sell its hospitals in Connecticut and Pennsylvania. Of additional concern are the reports of the status of the hospitals in Connecticut and Pennsylvania. PMH has a total of four (4) hospitals in Pennsylvania, two (2) of which have closed since PMH acquired Crozer Health system in 2016. It was reported that, in January 2022, PMH closed the emergency room, suspended ancillary services and cut the inpatient Acute Substance Abuse and Residential Substance Abuse Program at its Springfield Hospital in Pennsylvania. Additionally, PMH began reducing services at Delaware County Memorial Hospital, a 168-bed hospital in Upper Darby, Pennsylvania in January 2022. After subsequent reduction of services, including the maternity ward, the operating room, and the intensive care unit, the Pennsylvania Health Department shut down the facility due to serious health violations and inadequate staffing. Reports out of Pennsylvania describe the abruptness of the emergency department closure and the impact on communities previously served by Delaware County Memorial Hospital. A lawsuit was filed against PMH alleging that PMH was in violation of an agreement requiring it to maintain acute care services at its Pennsylvania hospitals for ten (10) years. This lawsuit has since been suspended to facilitate the sale of Crozer Health to a new owner.

PMH also owns three (3) hospitals in Connecticut: Waterbury Hospital, Manchester Memorial Hospital, and Rockville General Hospital. In February 2022, Yale New Haven Health System ("Yale") and PMH announced the signing of an agreement for Yale to acquire PMH's Connecticut health systems. Since the signing of this agreement, it is reported that negotiations have been challenging, as conditions at PMH's Connecticut hospitals have continued to deteriorate, including overdue payments to vendors, failure to pay physicians, and postponement of surgeries. On May 28, 2024, Yale sued PMH to terminate the agreement to acquire the hospitals, alleging that PMH breached the contract by allowing the Connecticut facilities to deteriorate, mismanaging assets, and failing to pay rent and taxes on time. On June 6, 2024, PMH then sued Yale, requesting that Yale honor its contractual obligations to acquire PMH's Connecticut hospitals. Resolution to these lawsuits, and the execution of the sale of PMH's Connecticut hospitals, remains unknown as of the date of this Decision.

In applying this criterion, RIDOH considers the character, commitment, competence, and standing in the community of all Transacting Parties. Therefore, PMH's intention to exit the East Coast market and its financial struggles were relevant to this review.

b. *Whether sufficient safeguards are included to assure the affected community continued access to affordable care.*

In reviewing this criterion, RIDOH considers the health care delivery system that is currently in place in the affected community and the commitments that the acquiror has made to the community in facilitating continued access to affordable care in the applicable service area, evaluating:

- the past and current financial status of the Transacting Parties;
- the Transacting Parties' projections of financial status post-affiliation;
- the Transacting Parties' specific plans, including efficiencies, reductions, consolidations and other methods which the Transacting Parties will use to achieve their financial goals;
- the reasonableness of these assumptions and the basis thereof;
- description of short and long term plans to assure access to healthcare services to the community; and
- the Proposed Transaction's potential or likely impact on availability and accessibility of services pre- and post-affiliation, including geographic access to specific services.

RWMC and OLF have long struggled financially, both as part of a larger system and while operating independently. PCC has been financially dependent on PMH since it was acquired in 2014. PYA Report, p. 8. Prior to PMH's ownership, in 2009, RWMC and OLF affiliated as CCHP, largely because neither could be self-sustaining alone. Despite some improvements due to that affiliation, CCHP continued to experience unsustainable losses, requiring the system to seek an outside buyer to provide capital infusion.

Based on the financial information provided in the Record, PYA observed the cash flows generated from PCC's stand-alone operations are not sufficient to fund PCC's operational obligations and necessary capital reinvestment. PYA Report, p. 8.[11] PCC's cash account had held a negative balance since at least September 30, 2020. Id. This negative balance represents checks written by PCC that have not been presented for payment. Id. When presented, PMH transfers funds to cover the checks. Id. In the last three and a half years, accounts payable have continued to grow substantially, while operating expenses grew marginally. Id. Throughout 2023, thirty percent (30%) of vendors that supply critical supplies to the hospitals were on credit hold status, meaning that those vendors would only deliver supplies if they were paid at the time of delivery.[12] There were further difficulties for PCC (and PMH) in August 2023, when a data security incident disrupted operations across the system. Based on the available information, PYA further observed that deferred capital and maintenance needs exist at the hospitals, suggesting that PCC is not able to adequately reinvest in its facilities and equipment. PYA Report, p. 12. Throughout the review, RIDOH heard management's perception of the major financial challenges for PCC, which include

[11] As described in PYA's Report, PCC has not issued audited financial statements since FY2022. The unaudited financial information was deemed confidential by RIAG, therefore, the report is provided in redacted form.
[12] See Immediate Compliance Order, filed In the Matter of: Chamber, Inc., et al., PC-2023-06468 (January 8, 2024). The Immediate Compliance Order provides further details of the financial history and challenges in recent years.

low reimbursement rates for Medicaid and Medicare patients and capped reimbursement rates for commercial payers, not focusing on revenue-generating activities, and being part of a national and regional system whose initiatives do not always align with the needs of the local system.

PMH, the ultimate parent company of RWMC and OLF, has likewise experienced financial difficulties in recent years. Over the past four years, PMH has experienced declining margins resulting in decreasing liquidity. PYA Report, p. 14. PYA observed PMH's financial instability has been growing for several years and is now acute. Id. Immediately prior to February 2023, PMH defaulted on two of its credit obligations. To obtain additional liquidity, PMH incurred debt and issued ownership to Medical Properties Trust ("MPT"). Id. PMH's agreement with MPT, a recapitalization plan, resulted in two loans totaling $400 million and a $50 million line of credit. In addition to issuing new credit capacity to PMH, MPT also obtained a non-controlling interest in PMH of approximately $654 million. Id. Despite these loans, PMH continues to have acute liquidity issues. Liquidity, profitability and operating margin—key financial metrics to determine the health of an entity—have largely declined over the past four years. Id. at 17. PYA observed PMH's reported days cash on hand has been precariously low. Id. Neither PMH nor PCC has issued audited financial statements for fiscal year 2023 as of the date of this Decision, well outside the time frame of industry standards. Given these observations, there is concern about PMH's ability to continue funding PCC's operating losses and capital expenditures.

The Transacting Parties represent that the New CharterCARE System will be self-sustaining, largely due to the financial savings associated with return to non-profit status, shifting operational focus back to patients and local needs, and achieving the many Improvement Initiatives. Centurion asserts that "[b]y having $80 million in cash on hand at closing, the New CharterCARE System at closing will be positioned for success and remain independent."[13] As mentioned above, these Improvement Initiatives are projected to provide $41 million in improvements in the first year. The Improvement Initiatives are identified within an EBITDA Bridge (as defined in PYA's Report) provided by the Transacting Parties. Many of the initiatives identified within the EBITDA Bridge do not have support, have very little support, or have not provided evidence of the relevant cost associated with certain initiatives. PYA Report, pp. 20-21. Additionally, Centurion submitted a Transition Plan to provide guidance for the necessary changes to implement the transition for the following areas:

1. Human Resources.
2. Information Technology.
3. Supply Chain Management.
4. Clinical Operations.
5. Workforce Adjustments.
6. Ambulatory and Outpatient Centers.
7. Strategic Market Adjustments.

[13] RIDOH's First Set of Supplemental Questions, Response to Question 21.

8. Physician Services.
9. Revenue Cycle Management.
10. Finance.
11. Managed Care Operational Changes.
12. Compliance.

The Centurion Transacting Parties have not provided a clearly defined budget or a plan for funding the Transition Plan. Essentially, the New CharterCARE System will have to achieve significant operational improvement while simultaneously affecting a complex transition plan to an independent system. Finally, closing of the Proposed Transaction is contingent upon financing to support the purchase price and adequate cash on hand for the New CharterCARE System. As stated in the PYA Report, immediate interventions will be necessary to remain in compliance with the anticipated financing obligations. Id. at 18-19.

Notably, the Proposed Transaction does not include any outside capital infusion and the New CharterCARE System, not Centurion, will be responsible for the debt associated with the transaction. As ultimate parent, it is the responsibility of Centurion to support the New Hospitals fiscally.

To address these concerns, RIDOH has imposed conditions, as more fully described below, including requiring PMH to fund certain deferred maintenance and other essential capital projects and requiring Centurion to cover the operating expenses of the New CharterCARE System.

c. Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.

To determine whether the Transacting Parties have provided clear and convincing evidence that the proposed affiliation will provide healthcare and appropriate access with respect to traditionally underserved populations in the affected community, RIDOH will consider:

- the Transacting Parties' history of providing care to underserved populations, including the provision of charity care;
- identification of any services provided by the Transacting Parties which are considered critical due to short supply or uniqueness;
- evidence that the Transacting Parties provide and will continue to provide care that welcomes and accommodates multilingual and multicultural populations and individuals with disabilities; and
- the Transacting Parties' history of and plan for providing community benefits.

RWMC and OLF have historically provided care to the underserved. The hospitals operate adult and geriatric psychiatric inpatient units, as well as outpatient psychiatric services that are critical components of Rhode Island's behavioral health care delivery system. RWMC has the state's only Level IV Alcohol & Drug Detoxification Program. The hospitals have between 50,000 to 60,000 emergency room visits per year. In the Rhode Island hospital market, RWMC and OLF provide a substantial number of services lines such as 9.6% to 15.2% statewide volume of medical admissions across most major categories including respiratory, circulatory, digestive, hepatobiliary, endocrine and metabolic, kidney and urinary tract, and infectious diseases; 38.3% (2021) to 44.7% (2022) statewide volume of inpatient surgery for nutritional and metabolic diseases (e.g., bariatric surgery); 21.5% (2021) to 21.7% (2022) statewide volume of inpatient mental health treatment; and 25.2 % (2022) to 27.0% (2021) statewide volume of inpatient treatment for alcohol and drug use and disorders. See Quality Report, p. 7.

RWMC and OLF largely serve Medicaid and Medicare populations. PCC issued a Community Health Needs Assessment ("CHNA") in 2022, which identified three priority areas: behavioral health, chronic disease, maternal and child health. The Existing Hospitals have made efforts to ensure adequate and appropriate access by:

- Recruiting minority physicians and other providers that include primary care and specialty care, behavioral health and addiction medicine experts;
- Operating primary care locations and graduate medical education and training, which provides underserved populations with easily accessed, affordable primary health care services for children and adults, as well as sub-specialty services and emergency room access;
- Providing financial resource counselors work with uninsured patients on applying for available assistance to eliminate financial barriers to care;
- Supporting area social service agencies like RI Food Bank, Smith Hill Development Center, Tri-County Community Action, Crossroads RI, Family Service of RI, Sojourner House and the RI Free Clinic; and
- Implementing comprehensive marketing and communications program, including billboards, digital social media, and print and radio (including to outlets that primarily focus on underserved communities).[14]

RIDOH regulations provide a built-in safeguard for the provision of charity care. Pursuant to the Rules and Regulations Pertaining to Hospital Conversions, 216-RICR-40-10-23.14, hospitals must provide full charity care (i.e., a 100% discount) to patients/guarantors whose annual income is up to and including 200% of the Federal Poverty Levels ("FPL"), taking into consideration family unit size. Hospitals must also provide partial charity care (i.e., a discount less than 100%) to patients/guarantors whose annual income is between 200% and up to and including 300% of the FPLs, taking into consideration family unit size.

[14] HCA Application, Response to Question 65.

Centurion plans to "enact robust charity care policies" and will continue to meet the standards regarding providing medically necessary and emergency medical care regardless of a patient's ability to pay. Additionally, the New CharterCARE System will continue to provide services to Medicaid and Medicare patients, which account for approximately sixty to seventy percent (60-70%) of its revenue. The New CharterCARE System will continue and strengthen its efforts in the three priority areas identified in the CHNA and plans to form a community advisory board to advise leadership on issues related to the CHNA, including management of community benefits and charity care. It will manage community benefits and charity care through its CHNA process and in accordance with RIDOH's Hospital Conversions Regulations.

RWMC and OLF have a significant history of serving underserved and low-income populations and Centurion has provided plans to assure continued access to affordable care for patients within the communities they serve.

d. Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital.

Section 1877 of the Social Security Act prohibits a physician from referring patients to an entity for a designated health service ("DHS") if the physician or a member of his or her immediate family has a financial relationship with the entity, unless an exception as specified in 42 CFR Part 411(J) applies. The law also prohibits an entity from presenting a claim to Medicare or to any person or other entity for DHS provided under a prohibited referral. No Medicare payment may be made for a DHS rendered as a result of a prohibited referral, and an entity must refund any amounts collected for a DHS performed under a prohibited referral on a timely basis. Civil monetary penalties and other remedies may also apply under some circumstances.

The New Hospitals will become non-profit corporations and their sole member will be a non-profit organization. Therefore, ownership interests in the New Hospitals will not be available to any third party, including hospital employees or physicians.

e. Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce.

In order to determine whether the Transacting Parties have provided satisfactory evidence of their commitment to assure the continuation of collective bargaining rights, RIDOH considers:

- the Transacting Parties' description of collective bargaining issues that may be raised by the proposed affiliation;

- plans to address those issues;
- evaluation of the commitment demonstrated in the Transacting Parties' plan to assure continued collective bargaining rights of employees;
- evidence that the Transacting Parties sought and considered the input of employees and employee union representatives in such plans; and
- any comments provided by employees and employee union representation.

The Centurion Transacting Parties have stated that they have no plans to reduce staffing levels. The number of full-time employees at PCC's licensed facilities is projected to remain relatively the same through fiscal year 2029.[15] It has been represented that the Proposed Transaction will return positions to the Rhode Island market as a result of returning corporate functions to the local system and local recruitment. Further, Centurion represented that it has secured 100% retention of targeted leadership positions. According to the Record, Centurion has not finalized a retirement plan or other benefits for the New CharterCARE System but represents any plan developed will be substantially similar to, or better than, the plans that currently exist for employees.

Both RWMC and OLF have collective bargaining agreements with UNAP. According to Callaci, UNAP represents approximately 1,200 individuals who work at RWMC, OLF, and Prospect Home Health and Hospice. Those represented across the system include registered nurses, non-nursing professionals, technical, and other support staff. The vast majority of UNAP members are employed at OLF. Over the course of the public meetings and through written public comment, UNAP representatives largely opposed the Proposed Transaction. Callaci provided both written and oral comments, expressing concerns about the viability of Centurion's business model, lack of relevant experience, and misrepresentations regarding employee benefits. At both public meetings, Mingle expressed that Centurion is committed to working with the union to come to a continued agreement. According to Callaci, no agreements have been reached to date.

RIDOH has taken all of this information under consideration in rendering this Decision.

f. Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring.

In considering this criterion, RIDOH recognizes hospitals that are affiliating should make reasonable efforts to retrain employees for new positions if their job is eliminated, with a goal of minimizing disruption of employment as a result of the conversion to the extent possible. RIDOH considers the Transacting Parties' description of the planned consolidation, elimination, or expansion of functions/positions as a result of the affiliation and the Transacting Parties' demonstration that current and planned staffing levels are adequate.

[15] HCA Application, Appendix A.

As stated above, the Transacting Parties have represented that there is no anticipated change, reduction, or elimination of services resulting from the Proposed Transaction. Centurion expects additional corporate functions to be brought back to the state. With that said, there are questions as to whether the Existing Hospitals maintain the adequate staff necessary, in particular in direct patient care areas. RIDOH and its quality consultants observed that RWMC and OLF have operated with minimum requirements for sufficient staffing, specifically in areas such as nursing and security.

These observations are considered in the context of the financial challenges of PCC. Based on the observations of PYA, PCC faces a daunting challenge to materially improve operations without significant additional volume and/or restructuring. PYA Report, p. 14. It is expected that the CRO, in conjunction with the Chief Quality Officer ("CQO"), will review staffing levels and implement any necessary changes to staffing levels and retraining.

g. Whether the conversion demonstrates that the public will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

RIDOH views this criterion as a representative summary of the statutory criteria, and related issues, in determining if the public interest will be served by approving the Proposed Transaction. In reviewing this criterion, RIDOH will consider:

- Any relevant history of quality concerns within the facilities of the existing hospitals;
- the Transacting Parties' description of short and long term plans to assure the provision of safe, high quality healthcare services to the community;
- any description of changes to quality structures and processes, including the organizational structure that will be used for clinical quality management, oversight, and enforcement;
- plans and timelines for development and implementation of consistent clinical, quality, and patient safety policies and procedures across the new entity; and
- description of plans to improve quality and patient safety through the further development of health information systems.

The Transacting Parties represent that the New CharterCARE System will continue to provide quality, cost-effective services to members of the Rhode Island community and with the support of Centurion, the New CharterCARE System will explore opportunities for clinical improvements to drive high performance. As represented in the Record, the New CharterCARE System will increase access to primary care and other specialty services, work on inpatient behavioral health to ensure community demand is addressed, update the emergency department at OLF, and other initiatives that it asserts will provide additional quality care and reduce health costs. The existing

quality assessment and performance improvement ("QAPI") plans will continue to be used and were updated after filing of the HCA Application.[16]

There have been several regulatory actions against the Prospect Transacting Parties in recent months. Last November, RIDOH issued an Immediate Compliance Order, pursuant to R.I. Gen. Law §§ 23-1-1, 23-1-17, and 23-1-21, against the Prospect Transacting Parties related to the signs of financial instability and their direct impact at RWMC and OLF. Specifically, the days in accounts payable had ballooned and many vendors were on credit hold. As a result, it was reported that at least nineteen (19) surgeries were cancelled due to lack of equipment or supplies. Additionally, during this timeframe, there have been immediate jeopardy citations at OLF, and numerous other citations across multiple clinical domains at RWMC. See Quality Report, pp. 13-14 (summary of citations). CMS defines immediate jeopardy as "a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident." See 42 C.F.R. Sections 481.51, 482.12; see also State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy.

RIDOH's quality consultant likewise identified several areas of concern related to the existing system's ability to provide safe and adequate treatment. A review of the QAPI plans revealed significant evidence of deficiencies in the quality improvement plans under which Centurion will operate the New CharterCARE System hospitals. See Quality Report, pp. 15-16.

There is significant evidence of deferred maintenance of the physical facilities, such as the roofs at both RWMC and OLF that require replacement. Id. at 9. Additionally, a cooling tower at RWMC and condenser fan motor at OLF are in need of replacement. Id. Other equipment and software are largely outdated, such as the archaic electronic medical records system, inpatient beds that do not serve the patients' needs, and dated imaging equipment. Id. at 9-10. This level of deferred maintenance is supported by the financial findings in PYA's Report. Finally, there was evidence of necessary improvements to security at both RWMC and OLF. Id. at 10. These observations exemplify the separation of the financial management at the PMH corporate level from the operational management at the local level. This separation makes it difficult for the local management to get the funding for priority needs they have identified.

As a result of the concerns identified, RIDOH has issued several conditions to improve quality under the new ownership, including appointment of a CRO and CQO.

[16] The QAPI plans are provided in HCA Application, Response to Question 65.

h. Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval for any previous conversion pursuant to an application submitted under § 23-17.14-6.

The Centurion Transacting Parties have not previously been subject to any conversion under the HCA. Therefore, this condition does not apply.

i. For any conversion subject to this chapter, the director shall consider issues of market share especially as they affect quality, access, and affordability of services.

The Transacting Parties reported that no filing is required with the Federal Trade Commission for this Proposed Transaction. Furthermore, Centurion does not own or operate any healthcare facilities. As a result, the Proposed Transaction will have no immediate effect on market share.

IX. Final Decision and Conditions

The HCA Application was reviewed in accordance with the requirements of HCA and RIDOH hereby approves the Application with Conditions.

In accordance with the HCA, below are the conditions of approval set forth by RIDOH.

General:

1. Prior to closing of the Proposed Transaction, the Transacting Parties shall execute a Transition Services Agreement ("TSA") for services to be provided by PMH to the New CharterCARE System. The services under the TSA shall be provided for the length of time Centurion and/or the New CharterCARE System deem necessary, shall include any and all services currently provided by PMH as requested by Centurion and/or the New CharterCARE System, and shall be provided at the present cost incurred by PMH. The TSA shall be provided to RIDOH for review and approval at least thirty (30) days prior to the close of the Proposed Transaction.

2. After the New CharterCARE System entities have been designated as tax-exempt by the Internal Revenue Service ("IRS"), Centurion shall assign all of its rights under the Asset Purchase Agreement (the "Assignment") to the New CharterCARE System or its subsidiaries, as applicable, prior to close of the Proposed Transaction. The Assignment shall be provided to RIDOH for review and approval at least thirty (30) days prior to close of the Proposed Transaction.

3. Any material deviation of the terms of the proposed financing structure for the Proposed Transaction shall require notice and approval of RIDOH.

4. The Transacting Parties shall provide a detailed plan that demonstrates how the Provider Numbers with governmental, commercial, and managed care providers, and National Provider Identifiers will be transferred to, or obtained by, the New Hospitals and how reimbursement will continue immediately upon close of the Proposed Transaction. This plan shall be provided to RIDOH within thirty (30) days of this Decision.

5. The Transacting Parties shall continue to fund all costs and expenses associated with all experts and consultants pursuant to R.I. Gen. Laws § 23-17.14-13 through closing of the Proposed Transaction. The Transacting Parties shall replenish the escrow accounts in accordance with the Reimbursement and Escrow Agreement dated May 26, 2023, within one (1) week of this Decision. All costs and expenses pursuant to the Reimbursement and Escrow Agreement dated May 26, 2023, shall be paid in full prior to closing of the Proposed Transaction.

6. Any net cash payable to PMH at the closing of the Proposed Transaction shall be held in a closing escrow, which shall be established pursuant to an escrow agreement acceptable to RIDOH, until Conditions 1, 23, 24, 25, 27, and 30 have been satisfied.

7. The Transacting Parties shall update and/or supplement responses to the HCA Application or any Supplemental Questions until closing of the Proposed Transaction.

Hospital Management:

8. The New CharterCARE System shall appoint a systemwide Chief Quality Officer ("CQO"), who shall be a currently licensed health professional other than the Chief Nursing Officer, and who shall, at a minimum, be accountable for leading all quality councils and overseeing implementation of any improvement and safety plans. The Centurion Transacting Parties shall provide the name and experience of any individual that holds this position to RIDOH.

9. The Transacting Parties shall appoint a Chief Restructuring Officer ("CRO"), experienced in healthcare turnarounds, within sixty (60) days of this Decision.

    a. The CRO shall be appointed to provide services, including but not limited to managing and guiding PCC and/or the New CharterCARE System's day-to-day business affairs, overseeing and maintaining a weekly cash flow projection in coordination with other management and personnel and any other related financial management, assisting PCC and/or the New CharterCARE System in exploring

strategic alternatives, and any other duties as more fully defined in an agreement between the CRO and PCC and/or the New CharterCARE System.

b. The CRO shall be designated as an officer of the company and report directly to PCC and/or the New CharterCARE System's board of directors or similar governance body.
c. The agreement between the Transacting Parties and the CRO referenced in subsection (a) herein shall be approved by RIDOH.
d. The CRO shall be approved by RIDOH.
e. The CRO shall not be a current employee, consultant or independent contractor, of any Transacting Party.
f. The CRO fees shall be paid by PCC and/or the New CharterCARE System.
g. The CRO shall report to RIDOH on a weekly basis, or as otherwise agreed upon by RIDOH, and shall prepare or provide any information and documentation requested by RIDOH.
h. Within four (4) weeks of the CRO's appointment, the CRO shall prepare and/or validate a 13-week cash flow projection, including analyzing historical cash disbursements and receipts and results of operation to determine the reasonableness of projected cashflows and short-term cash needs. A copy of said 13-week cash flow projection shall be provided to RIDOH. Subsequently, the CRO shall produce 13-week cash flow projections, if requested by RIDOH.
i. The Transacting Parties shall implement any recommendations or initiatives of the CRO, as approved by the board, with prior review and approval of RIDOH.
j. PCC and/or the New CharterCARE System must maintain a CRO until such time as PCC and/or the New CharterCARE System is cash flow positive for three consecutive quarters, and with RIDOH's prior notice and approval.

10. Centurion shall be required to employ the asset manager to oversee the New CharterCARE System for at least five (5) years after the closing of the Proposed Transaction. Centurion shall provide the name and experience of any individual that holds this position to RIDOH.

Hospital Operations:

11. To the extent the New CharterCARE System is unable to fund the following: payroll obligations (retirement and benefits); all taxes (including but not limited to property, sales, and employment); any and all debt servicing; and vendor payments of the New CharterCARE System on a timely basis, Centurion shall cover such obligations to keep the New CharterCARE System in good standing with these obligations. "Timely basis" shall mean sixty (60) days for all vendor payments and fifteen (15) days for all other obligations unless otherwise prescribed by local, state, or federal laws or regulations.

12. The governing bodies for CharterCARE Health of Rhode Island, CharterCARE RWMC, CharterCARE OLF, and CharterCARE Health of Rhode Island Foundation, Inc., shall include, at a minimum:

    a. At least nine (9) directors;
    b. A licensed and practicing physician with experience in hospital operations, as well as directors that have adequate experience in matters including financial, legal, business, labor, investments, community purpose, health care, diversity and who represent diverse populations of the affected communities served by the New Hospitals; and
    c. At least sixty-seven percent (67%) of directors who are independent of, and not employed by or affiliated with, Centurion or its affiliates.

13. All board members of CharterCARE Health of Rhode Island, CharterCARE RWMC, CharterCARE OLF, and CharterCARE Health of Rhode Island Foundation, Inc. shall be required to complete fiduciary training on an annual basis and provide certification of completion to RIDOH, with the first such training to occur within ninety (90) days of closing of the Proposed Transaction.

14. There shall be no elimination or significant reduction in health care services provided within the New CharterCARE System for a period of five (5) years from the issuance of the licenses within the New CharterCARE System without prior approval by RIDOH. For the first three (3) years following the issuance of the licenses within the New CharterCARE System, "significant reduction" shall mean any reduction of ten percent (10%) of more of its hours of operation, ten percent (10%) or more of staff for any services, or any other material reductions of services. For the subsequent two (2) years thereafter, significant reduction shall mean any reduction of twenty-five percent (25%) or more of its hours of operation; twenty-five percent (25%) or more of staff for any services; or any other material reductions of services. In no event shall there be *any* reduction or elimination of the emergency department or any behavioral health units at either RWMC or OLF without prior notice and approval of RIDOH.

15. The Transacting Parties shall maintain sufficient staffing of management, clinical, administrative and all other functions to ensure continuity through the transition period from PCC to the New CharterCARE System.

16. The CQO and CRO shall collaborate to address employment needs at all facilities and address workforce retraining needed as a result of the findings of the CRO.

Health Information Technology:

17. The New CharterCARE System shall ensure continued participation in CurrentCare, or the equivalent statewide Health Information Exchange (HIE).

18. Centurion and/or the New CharterCARE System shall provide complete and timely electronic information in response to requests from RIDOH regarding the *RIDOH Statewide Health Inventory.*

Health Equity and Quality:

19. Within sixty (60) days after closing of the Proposed Transaction, the New CharterCARE System shall adapt the "Quality and Patient Safety Assessment and Performance Improvement Plan effective for Calendar Year 2023-2028" to meet the distinct needs of each hospital as more fully described in Appendix C.

20. That for a period of no less than five (5) years, the Transacting Parties shall ensure that the Rhode Island licensed health care facilities report quarterly on quality improvement initiatives as determined by RIDOH.

21. Centurion shall ensure that the New CharterCARE System shall maintain compliance with the federal *National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards),* published by the Office of Minority Health, U.S. Department of Health & Human Services.

Financial:

22. Chamber and/or PMH shall satisfy all PCC accounts payable balances that are over thirty (30) days past due and any single invoice with a balance that is over seven hundred and fifty thousand dollars ($750,000) as of the close of the Proposed Transaction.

23. Chamber and/or PMH shall fund the following maintenance, purchase of equipment and updates to services as follows:

    a. Replacement of the roofs and any necessary mold remediation at both RWMC and OLF;
    b. Replacement of the cooling tower at RWMC and the condenser fan motor at the OLF Emergency Department;
    c. Replacement of the magnetic resonance imaging (MRI) equipment at OLF and the highest priority unresolved needs for imaging at RWMC (e.g., computed tomography and/or nuclear medicine);
    d. Upgrade of the electronic health record (EHR) system at RWMC and OLF to Meditech Expanse or a product with similar capabilities, including the ability to support:
        - a cloud-based platform to support connection with remote sites (e.g., medical offices);

- integration of key modules including operating room management, emergency department management, and pharmacy management;
- recording of vital signs, point-of-care glucose values, and other critical information at the bedside using hand-held devices or mobile equipment with automated data transfer; and
- improved adherence with barcoded medication administration to reduce medication-related errors; and

e. Provide new inpatient beds to replace beds that no longer provide optimal functionality to prevent pressure injuries, to reduce occupational health risks related to moving patients in bed and transferring patients out of bed, to reduce the risk of falls among high-risk patients, and to ensure that patients can contact nursing staff (and nurses can contact other staff) in a convenient, timely, and reliable manner.

All plans and funds for the completion of the above shall be secured prior to closing of the Proposed Transaction. Chamber and/or PMH shall be solely financially responsible for the above and the Proposed Transaction shall not be closed without written approval from RIDOH that this Condition has been satisfied.

24. Chamber and/or PMH shall develop and implement an updated security management plan, based on a complete risk assessment, pursuant to The Joint Commission standard (Environment of Care) EC.01.01.01 EP (Element of Performance) 5 and EC.02.01.01 EP 1 and EP 3. Specifically, the latter Elements of Performance require accredited facilities to:

a. Implement "its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts."
b. Take "action to minimize or eliminate identified safety and security risks in the physical environment."

This updated security plan shall include an updated risk assessment and shall meet the requirements set forth in Appendix D.

All plans and funds for the completion of the above shall be secured prior to closing of the Proposed Transaction. Chamber and/or PMH shall be solely financially responsible for the above and the Proposed Transaction shall not close without written approval from RIDOH that this Condition has been satisfied.

25. Chamber/PMH shall satisfy the outstanding Health Professional Loan Repayment Program funding amount of seventy-five thousand dollars ($75,000) pursuant to Condition 24 of RIDOH's June 1, 2021 Hospital Conversions Act Decision.

26. Centurion shall contribute a minimum of seventy-five thousand dollars ($75,000) annually, for five (5) years, in conjunction with the initial and renewed license, to the Health Professional Loan Repayment Program administered by RIDOH, to defray health professional student loan debt of primary care health providers (as defined by the Federal Bureau of Health Work Force) practicing in the state of Rhode Island.

27. Chamber/PMH shall satisfy the outstanding amount of one-hundred and fifty thousand dollars ($150,000) to support the state's coordinated health planning process, including but not limited to the Statewide Health Inventory Program pursuant to Condition 25 of RIDOH's June 1, 2021 Hospital Conversions Act Decision.

28. Centurion shall contribute annually, in conjunction with the initial and renewed licenses, a sum of one-hundred and fifty thousand dollars ($150,000) to support the state's coordinated health planning process, including but not limited to the Statewide Health Inventory Program.

29. Centurion or any other affiliated entity shall not assess administrative or management fees to the New CharterCARE System above and beyond the fees contemplated by the Corporate Services Agreement ("CSA"). For a period of five (5) years, the fees contemplated under the form of CSA provided in HCA Application shall not be modified without notice and approval of RIDOH.

30. PMH shall cure any defaults, delinquencies, or other similar issues related to the Property Assessed Clean Energy ("PACE") loans prior to close of the Proposed Transaction.

31. In the event the New Hospitals assume the PACE loans and are unable to satisfy any and all obligations owed by the New Hospitals for PACE financing, including all debt service payments, fines, penalties and any other PACE related costs and expenses during Centurion's ownership of the New CharterCARE System, then Centurion shall satisfy such obligations to keep the New Hospitals in good standing with any and all PACE lenders.

32. The New Hospitals, and any of their Rhode Island regulated affiliates, shall not file a petition for voluntary bankruptcy, seek the appointment of a receiver, special master or similar in-court or out-of-court insolvency fiduciary, or cause any other person or entity to commence an involuntary insolvency proceeding, related to or against the New CharterCARE hospitals in any forum other than within the State of Rhode Island.

33. Centurion shall be prohibited from collecting any revenue or other assets (except for the fee under the CSA as described herein) from the New CharterCARE System to

fund Centurion or any other subsidiary's operations outside of the New CharterCARE System.

34. No preliminary or final agreement for the sale, sale and leaseback, liens, mortgages, or other encumbrances of the Rhode Island hospitals' real estate shall be executed without prior review and written approval of RIDOH.

Reporting:

35. The Transacting Parties shall provide immediate notice, with supporting documentation, of all key milestones prior to closing of the Proposed Transaction, including but not limited to:

    a. An updated timeline from Barclays Capital, Inc., or any other underwriter retained to obtain financing, that includes key milestones and specific dates to achieve those milestones. This timeline shall continue to be updated as milestones are achieved, or as deadlines change;
    b. Start of and completion of Feasibility Study, including providing a copy of the final report;
    c. Securing the financing, including documents related to all terms of the financing;
    d. The PACE loans lender's consent or refusal to consent to the assignment of loans from the existing borrower to the new borrower;
    e. Updates on communication with the IRS regarding approval of tax-exempt status of the New CharterCARE System; and
    f. Any and all third-party consents that are required to complete the Proposed Transaction.

36. The Transacting Parties shall provide to RIDOH all information and documentation, as further described in Appendix E.

37. Any and all information or documentation submitted pursuant to the Conditions herein shall include a completed Attestation in the form provided in Appendix F.

38. PMH and Centurion, each and separately, will appoint an individual, acceptable to RIDOH, to be the point of contact for RIDOH's monitoring of these Conditions, who shall:

    a. Coordinate and cooperate with RIDOH to facilitate responses to all document requests and requests for meetings within an expedient and timely manner;
    b. Be responsible for identifying all persons from their respective entities who have requisite knowledge of the specific information, documentation, and meeting requests that are made on behalf of RIDOH;

c. Ensure to render these individuals readily available and ensure continuity and timeliness for any and all requests related to RIDOH's monitoring of the Conditions; and
d. Will, upon request, immediately and expeditiously consult with the appropriate bodies at RIDOH to provide all information pertaining to the Conditions.

39. The New Hospitals shall, on a weekly basis, on a form prescribed by RIDOH, provide Daily Counts (i.e., Sunday, Monday, Tuesday, etc.) for the Number of Staffed Beds per Cost Center, Number of Occupied Beds per Cost Center, Number of Vacant/Available Beds per Cost Center, and Number of Emergency Department Visits at CharterCARE RWMC and CharterCARE OLF.[17]

Monitoring and Compliance:

40. For a period of five (5) years, post-closing of the Proposed Transaction, Centurion and the New CharterCARE System shall file reports with RIDOH on or before March 1st of each calendar year attesting to compliance with these conditions.

41. Centurion shall abide by the Reimbursement and Escrow Agreement, executed on June 13, 2024, between RIDOH and Centurion, and Centurion shall fund the costs during the "Monitoring Period," which shall begin upon issuance of this Decision and continue for a further five (5) year period, commencing on RIDOH's issuance of licenses to the New Hospitals for RIDOH to monitor, evaluate, and assess compliance of the conditions of approval set forth herein, including through the engagement of financial, legal, and monitoring consultants, whether via full-time employees and/or contractors, at RIDOH's discretion.

42. The Transacting Parties and any and all subsidiaries shall provide, within a reasonable time, any and all additional information requested by RIDOH to confirm compliance with all Conditions stated herein.

43. If any of the foregoing conditions remain outstanding at the conclusion of the Monitoring Period referenced in Condition 41, Centurion shall be required to continue to fund the costs to monitor, evaluate, and assess compliance of the conditions of approval set forth herein, including through the engagement of financial, legal, and monitoring consultants, whether via full-time employees and/or contractors, at RIDOH's discretion, until such time as RIDOH deems the Conditions satisfied.

[17] Staffed Beds are defined as all beds, both Occupied and Vacant/Available, that are licensed and physically available for which staff is on hand to attend to the patient who occupies the bed. Occupied Beds are defined as beds that are licensed, physically available, staffed, and occupied by a patient. Vacant/Available Beds are defined as beds that are vacant and to which patients can be transported immediately; these beds are licensed, physically available, and have staff on hand to attend to the patient who occupies the bed.

44. If approved, any and all conditions imposed in any decision on the pending CEC Applications will be deemed Conditions of Approval for purposes of this Decision.

45. All conditions of RIDOH's June 1, 2021 Hospital Conversions Act Decision continue to remain in full force and effect until such time as RIDOH has made a written determination that all conditions have been satisfied.

The conditions set forth above shall be enforceable and have the same force and effect as if imposed as a condition of licensure in accordance with R.I. Gen. Laws §§ 23-17 and 23-17.14. RIDOH may take appropriate action, in the sole discretion of the Director, to enforce compliance with these conditions.

If any of the aforesaid conditions or the applications thereof to any person or circumstances is held invalid, that invalidity shall not affect any other condition or application of any other condition which can be given effect without the invalid provision, condition, or application, and to this end the conditions and each of them are declared to be severable.

Rhode Island Department of Health

_____

Jerome Larkin, MD
Director, Rhode Island Department of Health

6/20/2024

_____

Date

Appendix A

Summary Report on Hospital Conversion Act Application Involving Prospect CharterCARE

Report Date: May 28, 2024

Prepared for
Rhode Island Department of Health

PYA

PYA, P.C.
One Cherokee Mills
2220 Sutherland Avenue
Knoxville, TN 37919
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May 28, 2024

Fernanda Lopes, MPH
Chief, Office of Health Systems Development
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5097

Re: Hospital Conversion Initial Application of Chamber Inc.; Ivy Holdings Inc.; Ivy Intermediate Holdings, Inc.; Prospect Medical Holdings, Inc.; Prospect East Holdings, Inc.; Prospect East Hospital Advisory Services, LLC; Prospect CharterCARE, LLC; Prospect CharterCARE SJHSRI, LLC; Prospect CharterCARE RWMC, LLC; The Centurion Foundation, Inc.; CharterCARE Health of Rhode Island, Inc.; CharterCARE Roger Williams Medical Center Inc.; and CharterCARE Our Lady of Fatima Hospital, Inc. (the Transacting Parties)

Dear Ms. Lopes:

As outlined in the Memorandum of Agreement dated April 1, 2023, and amended as of April 2, 2024 and April 23, 2024, PYA, P.C. (PYA) was engaged by the Rhode Island Department of Health (RIDOH) to provide consulting services concerning the proposed hospital conversion application as resubmitted November 14, 2023 (Application), and relating to a transaction involving the Transacting Parties (Transaction). RIDOH is authorized and directed to review the conversion application pursuant to the provision of Chapter 23-17.14 of the Rhode Island General Laws, as amended (the Act or HCA). We prepared the following summary report (Report) solely to assist RIDOH with its review of the Application.

Our engagement was conducted in accordance with Consulting Standards established by the American Institute of Certified Public Accountants (AICPA). The terms of this engagement were established in advance and PYA's services to RIDOH are detailed in ***Appendix A***. We make no representation regarding the sufficiency of the procedures performed or analysis detailed herein either for the purpose for which this Report has been requested or for any other purpose. The results of our engagement are summarized in the following Report.

The procedures used in preparation of this Report do not constitute an audit, examination, or review of any of the Transacting Parties' historical financial statements in accordance with auditing standards generally accepted in the United States of America. Furthermore, the procedures used do not constitute an examination or compilation of prospective financial statements, nor did we apply agreed-upon procedures to such information, in accordance with attestation standards established by the AICPA. Additionally, PYA is not responsible for testing, evaluating, or identifying any occurrences of fraud or other illegal acts, if any. In performing our analysis, PYA relied upon information provided by the Transacting Parties and their representatives, including legal counsel, and we have not validated the accuracy or completeness of such information. Accordingly, we express no opinion, or any other form of assurance, related to this information, including historical financial information and Transacting Parties' management representations. Had we performed additional procedures beyond those established in advance, other matters might have come to our attention that would have been reported to you.

This Report is intended solely for the information and use of RIDOH and is not intended to be, and should not be, used by anyone other than the specified party. Accordingly, PYA assumes no liability for any unauthorized use of this Report.

The decision to approve the Application resides solely with RIDOH, and our Report does not constitute a recommendation regarding the disposition of the Application. Further, our Report should not be construed to render a valuation opinion of the Proposed Transaction. Additional details regarding our analysis and observations are contained in our workpapers. PYA has no responsibility to update our analysis or this Report for events and circumstances arising after the date of this Report. We appreciate the opportunity to assist RIDOH with this important matter.

Respectfully,

PYA, P.C.

PYA, P.C.

TABLE OF CONTENTS

ABBREVIATIONS

Entities

A&M	Alvarez & Marsal Holdings, LLC
Barclays	Barclays Investment Bank
BVS	Prospect Blackstone Valley Surgicare, LLC
CCHRI	CharterCARE Health of Rhode Island, Inc.
CCOLF	CharterCARE Our Lady of Fatima Hospital, Inc.
CCRWMC	CharterCARE Roger Williams Medical Center, Inc.
CCMA	Prospect CharterCARE Physicians, LLC d/b/a CharterCARE Medical Associates
Centurion	The Centurion Foundation, Inc.
Chamber	Chamber, Inc.
New CharterCARE or Buyer	The new CharterCARE System inclusive of CCHRI and its subsidiaries, CCOLF and CCRWMC
IH	Ivy Holdings, Inc.
IIH	Ivy Intermediate Holdings, Inc.
MPT	Medical Properties Trust, LP
OLF	Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital
Ovation	Ovation Healthcare, formerly known as QHR Health
PCC	Prospect CharterCARE, LLC
PCCHHH	Prospect CharterCARE Home Health and Hospice, LLC
PEH	Prospect East Holdings, Inc.
PMH or Prospect	Prospect Medical Holdings, Inc.
PRIHHH	Prospect RI Home Health and Hospice, Inc.
PYA	PYA, P.C.
RIAG	Rhode Island Attorney General
RIDOH	Rhode Island Department of Health
RWMC	Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center
UMG	New University Medical Group d/b/a University Medical Group
VMG	VMG Holdings LLC d/b/a VMG Health

Terms

ABL	Asset Based Loan
ACA	Affordable Care Act
Act or HCA	The Hospital Conversions Act pursuant to the provisions of Chapter 23-17.14 of the Rhode Island General Laws
APA	Asset Purchase Agreement by and between Centurion and PMH and each of the Selling Entities, dated as of November 18, 2022, and subsequently amended on April 18, 2023, and November 7, 2023.
Application	HCA Application submitted November 14, 2023
ASF	Audited Financial Statements
ASU	Accounting Standards Update
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CDM	Charge Description Master
CEO	Chief Executive Officer
CFO	Chief Financial Officer
Closing	The date the Transaction is consummated after meeting all closing conditions
CMS	Centers for Medicare & Medicaid Services
DCOH	Days Cash on Hand
[redacted]	[redacted]
EBITDA	Earnings Before Interest, Taxes, Depreciation, and Amortization
EBITDA Bridge	Analysis of EBITDA Efficiencies for CharterCARE Health of Rhode Island provided by Centurion on March 18, 2024
EMR	Electronic Medical Record
ERP	Enterprise Resource Planning
FASB	Financial Accounting Standards Board
FY	Fiscal Year
FYE	Fiscal Year End as of September 30th
FYTD	Fiscal Year to Date
GPO	Group Purchasing Organization
HHS	Department of Health and Human Services
Hospitals	OLF and RWMC
IRS	Internal Revenue Service
IT	Information Technology
LLC	Limited Liability Company
MOA	Memorandum of Agreement

MRA	Master Restructuring Agreement
NPI	National Provider Identifier
NPSR	Net Patient Services Revenue
NWC	Net Working Capital
PACE	Property Assessed Clean Energy
PTAN	Provider Transaction Access Number
REIT	Real Estate Investment Trust
Selling Entities	PCC; RWMC; OLF; PRIHHH; PCCHHH; BVS; UMG; CCMA; and Prospect CharterCARE Ancillary Services, LLC
SUO	Statement Under Oath
Transacting Parties	Chamber, IH, IIH, PMH, PEH, PCC, OLF, RWMC, Centurion, CCHRI, CCOLF and CCRWMC
Transaction	Asset purchase outlined in the APA by and between Centurion and PMH and each of the Selling Entities, dated as of November 18, 2022, and subsequently amended on April 18, 2023, and November 7, 2023.
Transition Plan	CharterCARE Health System Transition Plan updated March 14, 2024
TSA	Transition Services Agreement
TTM	Trailing Twelve Months
Year 1	The first calendar year immediately following the Closing

Individuals

Alfredo Sabillo	CFO, PMH
Ben Mingle	President, Centurion
Daniel Ison	Vice President of Finance, PCC
George Pillari	Chief Integration and Operations Improvement Officer, PMH
Jeff Liebman	CEO, PCC
Joseph Hegner	Managing Director, Barclays

ENGAGEMENT OVERVIEW

SCOPE OF WORK AND LIMITING FACTORS

Per the MOA between RIDOH and PYA, PYA was engaged to provide consulting services to RIDOH related to RIDOH's review of the Application. The following listing presents a summary of the services provided by PYA:

- Conducted meetings with RIDOH to confirm engagement scope and purpose;
- Analyzed relevant information provided by the Transacting Parties;
- Provided supplemental information requests;
- Analyzed supplemental information provided by the Transacting Parties and Transacting Parties' representatives;
- Attended SUOs conducted by RIDOH and the Office of the RIAG, as applicable to PYA's scope of work;
- Facilitated regular meetings with RIDOH representatives to discuss observations and engagement progress; and
- Prepared this Report documenting our observations.

A summary of our original scope of work, including limiting factors due to undisclosed information, is included in ***Appendix A.***

OVERVIEW OF PROPOSED TRANSACTION

TRANSACTING PARTIES

PMH

Per the Application, Chamber is a Delaware corporation with Sam Lee and the David Topper Family Trust each holding 50% interests. Chamber is the sole owner of IH, which is the sole owner of IIH. IIH is the sole owner of Prospect. Prospect is the sole owner of PEH. Chamber, IH, IIH, and PEH are each holding companies that do not provide services. PEH is the sole member of PCC. See the overview of the legal entity structure in ***Appendix B***. The Prospect transacting parties consist of Chamber, IH, IIH, Prospect, PEH, PCC and its subsidiaries.

PCC

PCC owns the operating entities of RWMC, OLF, BVS, and CCMA. In addition, RWMC wholly owns 1) PRIHHH, a home healthcare provider, which wholly owns PCCHHH, a licensed home nursing care provider and 2) UMG. All PCC entities are located in Rhode Island and are subject to the provisions of the Act.

RWMC is a licensed acute care hospital (license number HOSP00133) located in Providence, Rhode Island. Per the Application, RWMC is an academic medical center affiliated with Boston University School of Medicine and is accredited by the Joint Commission. OLF is a licensed acute care hospital (license number HOSP00132) located in North Providence, Rhode Island. Both RWMC and OLF provide a wide array of services to its patients, including emergency department, inpatient and outpatient services. BVS is a licensed freestanding ambulatory surgery center [redacted]. CCMA and UMG are multi-specialty physician practices.

Additional detail related to the Transaction and Transacting Parties are disclosed in the publicly available Application.

Centurion

Per the Application, Centurion is an Atlanta-based non-profit corporation formed in 1996 whose mission is centered upon increasing access to and lowering the cost of healthcare. In anticipation of the Transaction, Centurion formed CCHRI and its subsidiaries, CCOLF, CCRWMC, and CharterCARE Health of Rhode Island Foundation, Inc. Centurion is the sole member of CCHRI. The Application notes Centurion plans to establish legal entities for CharterCARE Blackstone Surgery Center, LLC; CharterCARE Physicians, LLC; CharterCARE Associates in Primary Care Medicine, LLC; and CharterCARE Home Health and Hospice, LLC, but as of the date of the Application, those entities had not yet been formed. Centurion plans to obtain 501(c)(3) status for CCHRI, but we understand that approval is still pending from the IRS. The Centurion transacting parties consist of Centurion, CCHRI and its subsidiaries, CCOLF, and CCRWMC.

PROPOSED TRANSACTION SUMMARY

The New CharterCARE affiliate entities propose to purchase substantially all of the operating assets of PCC and its subsidiaries. Per the Application, Centurion's strategy is to finance the Transaction in such a manner that New CharterCARE can be operated on a stand-alone basis as a self-sufficient 501(c)(3) health system. Centurion intends to obtain financing on behalf of New CharterCARE for approximately $160 million through new and existing debt instruments to pay the purchase price and place $80 million of cash on New CharterCARE's balance sheet. Centurion's role as the sole member, as documented in the Application, is that of enabling successes of New CharterCARE primarily through transaction strategy and execution of all aspects of the Transaction (e.g., structuring, underwriting, acquiring financing, etc.), conducted in such a way that it enables the local leadership team. Centurion has not committed to provide financial support to New CharterCARE nor guarantee New CharterCARE's debt. Centurion will charge to New CharterCARE a corporate administrative services charge equal to $750,000 annually for various administrative services, which are mainly oversight and advisory in nature. Additionally, New CharterCARE will pay $800,000 to Centurion upon Closing, from the acquisition financing proceeds, to reimburse Centurion for fees incurred to pursue the Transaction.

KEY TERMS OF THE APA AND FINANCING CONSIDERATIONS

The Transaction, as documented in the APA, includes a purchase price of $80 million to PCC for essentially all the assets (and current non-interest-bearing liabilities) of PCC less:

- Deposit of $5 million into an indemnity escrow account at the Closing;
- Any accrued and outstanding Acquisition Costs up to the APA defined acquisition cost budget of $2 million;
- The amount of a buyer note, if any;[1]
- The full outstanding amount of the PACE loans as of the Closing, less any escrow amounts held in the PACE escrow account;[2] and,
- Any shortfall of net working capital compared to the target net working capital of $0.[3]

The Transacting Parties are operating under the assumption that the value for the New CharterCARE System is $160 million, based on a VMG valuation report dated February 14, 2023. The VMG valuation report contained a fair market value range of $139 million to $161 million for the Prospect CharterCARE, LLC business enterprise. However, as New CharterCARE is assuming the outstanding PACE loan (approximately $45 million), the assumed value available for financing is $115 million. As a result, the $115 million value available for financing is the basis for the funding options under consideration by Centurion. Centurion expects to issue approximately $115 million in new taxable and tax-exempt bonds to fund the acquisition of the PCC assets by New CharterCARE.[4] The new debt will be utilized to fund the purchase price obligations and provide $80 million in cash for New CharterCARE. A summary of the purchase price funds flow and the financing sources and uses are summarized in ***Table 1***.

[1] Per SUO with Ben Mingle on May 6, 2024, and May 10, 2024, [redacted]
[2] Per documentation provided by the Transacting Parties from a [redacted] the PACE loans, net of escrow, approximate [redacted].
[3] As of PCC's March 31, 2024, unaudited, internal financial statements, assumed net working capital (as defined in the APA) approximated [redacted].
[4] Per [redacted] and as disclosed in Exhibit B of the Change in Effective Control Application last resubmitted April 18, 2024.

Table 1: Proceeds Required to Fund Transaction

(in millions)

Purchase Price Funds Flow:		
Purchase Price for PCC Assets and Operations[1]	$	80.0
Less: Indemnity Escrow[1]		(5.0)
Less: Acquisition Costs[1]		(2.0)
Less: Buyer Note		-
Less: PACE Loan Assumed, net of escrow amounts[2]		(45.2)
Less: Net Working Capital Shortfall[3]		[redacted]
Net Cash at Closing to PMH	**$**	[redacted]

Uses:		
Net Cash at Closing to PMH	$	[redacted]
Indemnity Escrow Funding		5.0
Reimbursement of Acquisition Costs		2.0
Working Capital Shortfall Funding		[redacted]
Opening Balance Sheet Liquidity		80.0
Estimated Funding Needed	**$**	**114.8**

Sources:		
PCC Assumed Fair Market Value	$	160.0
Less: PACE Loan Assumed, net of escrowed funds		(45.2)
New Debt (Taxable and Tax-Exempt Financing)	**$**	**114.8**

[1] Per APA.

[2] Per [redacted] and as disclosed in Exhibit B of the Change in Effective Control Application last resubmitted April 18, 2024.

[3] Per March 31, 2024 internal PCC balance sheet, with application of net working capital retained by Buyer per Confidential Exhibit 16.

The $80 million of cash is assumed to be the only source of capital for New CharterCARE; therefore, all working capital needs (since net working capital at close will be $0), capital expenditures, transition costs (including IT capital and one-time operating costs), and operational losses will need to be funded from this amount.

OBSERVATIONS SUMMARY

CONSIDERATIONS RELATED TO STATUTORY REVIEW CRITERIA

PYA began our analysis by gaining an understanding of the Act established by the state of Rhode Island. The purposes of the Act's provisions include assuring the viability of a safe, accessible, and affordable healthcare system; establishing a process to review whether hospitals will maintain, enhance or disrupt the delivery of healthcare in the state and to monitor hospital performance; and establish a review process and criteria for review of hospital conversions. In accordance with §23-17.14-11 of the Act, RIDOH considers the following seven statutory criteria in their assessment when reviewing applications pursuant to the Act.

- *Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties are satisfactory;*
- *Whether sufficient safeguards are included to assure the affected community continued access to affordable care;*

- *Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;*
- *Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;*
- *Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;*
- *Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;*
- *Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced healthcare delivery to the residents of the state.* [5]

PYA analyzed various financial, operational, and transaction-related documentation in context of these criteria, where applicable, to inform our analysis. This information, along with the interviews from various SUOs, form the basis for our following key observations.

PCC KEY OBSERVATIONS

Since PMH's acquisition, PCC has been dependent upon PMH to fund operational shortfalls and capital investments. This is evidenced by the reported intercompany payable to PMH of approximately [redacted] at March 31, 2024, which is representative of PMH's cumulative net funding of PCC. Such funding is necessary because PCC has incurred net operating and EBITDA losses in each year since FY2020.

- ***Key Financial Results –*** Based on our analysis of information provided by the Transacting Parties, PYA observed the cash flows generated from PCC's stand-alone operations are not sufficient to fund PCC's operational obligations and necessary capital reinvestment. The Transacting Parties provided documentation and testified in SUOs [redacted]. Certain financial information from PCC's FY2020 through FYTD March 31, 2024, financial statements are presented within ***Table 2.***

[5] "§ 23-17.14-11. Criteria for the department of health — Conversions limited to not-for-profit corporations." <http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.14/23-17.14-11.htm>, accessed on June 6, 2024.

Table 2					
PCC					
(Dollars in Thousands)	FY2020	FY2021	FY2022	FY2023^	FYTD 3/31/24^*
Income Statement					
Total Net Revenue	$322,211	$348,546	$349,989	[redacted]	[redacted]
Total Operating Expenses	372,671	365,208	377,787	[redacted]	[redacted]
Net Operating Loss before grants and investments	(50,460)	(16,662)	(27,798)	[redacted]	[redacted]
Net Loss	(15,061)	(16,809)	(29,351)	[redacted]	[redacted]
EBITDA	(41,536)	(5,797)	(25,165)	[redacted]	[redacted]
Balance Sheet					
Total Assets	$160,081	$157,568	$150,508	[redacted]	[redacted]
Total Liabilities	129,000	143,296	165,587	[redacted]	[redacted]
Total Stockholders Equity	31,081	14,272	(15,079)	[redacted]	[redacted]
Net Working Capital Surplus (Deficit)[1]	25,647	11,762	(21,870)	[redacted]	[redacted]
Cash Flow Statement					
Cash from Operating Activities	$57,574	$3,080	$7,886	[redacted]	[redacted]
Cash from Investing Activities	(55,240)	(4,485)	(5,897)	[redacted]	[redacted]
Cash from Financing Activities	(167)	(451)	(1,576)	[redacted]	[redacted]

^ *Unaudited*
* *The income statement has been annualized.*
[1] *Includes intercompany receivables (payables)*
NR Not reported

PCC's cumulative net loss from FY2020 to annualized FY2024 is forecasted to approximate [redacted] total assets [redacted] from $160 million as of FYE2020 to [redacted] as of March 31, 2024. During the same period, PCC's total liabilities [redacted] from $129 million to [redacted] (excluding operating lease liabilities). The primary driver of the [redacted] as of March 31, 2024. As described above, these related party payables represent funding by PMH when PCC was not able to fully fund its operations.

PCC has not issued audited financial statements since FY2022, and the timing is still uncertain as to when the FY2023 audited financials will be released. There have previously been significant delays in the issuance of audited financial statements, as the FY2022 audit was not released

until June 2023. For reference, publicly traded companies are required to release audited financial statements within 60 to 90 days after year end, depending on the company's classification under Rule 12b-2 under the Securities Exchange Act of 1934. By contrast, at the time of this Report, eight months have elapsed since the end of PCC's FY2023.

- ***Cash Management*** – PMH has centralized the treasury and cash management function for PCC and its other affiliates. Therefore, PMH transfers cash from PCC's bank accounts to PMH's bank account daily, resulting in a cash balance approximating zero on PCC's balance sheet.

  On March 31, 2024, PCC's cash account appeared to be [redacted] This was the [redacted] year ending negative balance since September 30, 2020. This negative balance represents checks written by PCC that have not been presented for payment. PMH will transfer funds to PCC's account to cover the disbursements to ensure that the checks are satisfied when presented for payment.

  PCC appears to have benefited from this centralized treasury approach, as operational cash flows produced by other PMH subsidiaries, whose cash management functions were also consolidated within PMH, were used to subsidize PCC's operations and capital needs. This is a standard practice for integrated health systems. However, the cumulative liability incurred by PCC of [redacted] as of March 31, 2024 demonstrates its dependency on PMH to fund operations and capital needs.

- ***Accounts Payable and Vendor Holds*** – Given the liquidity constraints experienced by PCC, the balance in vendor accounts payable has grown from nearly $31 million in FY2020 to [redacted] in March 2024, a [redacted] in slightly over 3.5 years. During the same period, operating expenses grew by [redacted] from approximately $373 million to [redacted]. Cash flow challenges have resulted in PCC's delayed payments to vendors. As presented in ***Table 3,*** at least [redacted] of both RWMC's and OLF's payables are [redacted] past due. Further, in March 2024, PCC's days in accounts payable (a metric which depicts the average time between invoice receipt and payment) approximated [redacted] days.

Table 3

PCC

Aged Accounts Payable as of 11/30/23 (Dollars in Thousands)	Total Unpaid Invoices	1 Month Overdue	2 Months Overdue	3 Months Overdue	Over 3 Months Overdue	Unallocated Amount
RWMC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
OLF	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

A consequence of the inability to pay vendors according to pre-negotiated payment terms was that certain vendors stopped delivering supplies to PCC which were necessary to provide patient care. On November 7, 2023, PCC received a letter from CMS alleging PCC had canceled procedures due to lack of supplies resulting from unpaid vendor invoices. As a result of the CMS finding, PCC formed a special committee,

Accounts Payable Task Force, in November 2023 to manage vendor payments. [redacted]. [redacted] Further, PYA learned that as of October 1, 2023, PCC had [redacted] vendors with a credit hold against the hospitals. According to information provided by Jeff Liebman in his May 14, 2024, SUO, [redacted].

- ***Related Party Transactions*** – As of March 31, 2024, PCC owed PMH nearly [redacted] This [redacted] obligation indicated that PCC cannot cover local operational expenditures and PMH support services costs. As shown in ***Table 4***, [redacted].

Table 4

PCC

(Dollars in Thousands)	FY2020	FY2021	FY2022	FY2023^	FYTD 3/31/24^
Receivable from (Payable to) affiliated companies, net	$32,458	$24,209	($18,637)	[redacted]	[redacted]

^ *Unaudited*

PMH executives explained that this related party obligation occurred for two reasons: [redacted]

In FY2020 and FY2021, PCC's financial statements and disclosures noted a related party receivable from PMH which is inconsistent with the related party payable to PMH recorded in PCC's financial statements from FY2022 [redacted] The related party receivable resulted from the $36 million of Provider Relief Funds pursuant to the CARES Act received by PCC during FY2020. Upon receipt into PCC's bank account, PMH transferred the funds to itself, which resulted in a temporary related party receivable. As the operational cash flow needs of PCC continued, the funds transferred from PMH amortized the receivable to zero until the continued activity resulted in a payable from PCC to PMH during FY2022. As described above, that payable amount has grown to approximately [redacted] by March 31, 2024.

- ***Debt Instruments*** **–** PCC entered into an agreement with a third party that specialized in PACE financing to fund qualifying capital projects at the Hospitals. This loan is collateralized by certain assets of the Hospitals. As of September 30, 2022,[6] the balance of this borrowing was [redacted] million. Based upon information submitted as part of the Application, it appears the current outstanding PACE balance approximates $45.2 million. However, in 2024, [redacted]. Per the SUO by Daniel Ison on May 13, 2024, "…[redacted] PYA understands [redacted]. According to PMH executives, [redacted]; therefore, PCC must rely on funding from its parent organization, PMH, for PCC's operational and capital cash needs.

- ***Cyber Incident*** **–** On August 1, 2023, PMH learned of a data security incident that disrupted the operations of some of its IT systems. This cyber incident impacted several PMH facilities, including those in Rhode Island, [redacted] During his SUO on May 8, 2023, George Pillari [redacted]. While information detailing the financial impact specific to PCC has not been provided, we understand that PMH's total loss [redacted].

- ***Capital Spending*** **–** Healthcare organizations must consistently reinvest in their facilities and equipment to maintain quality and a competitive position within their communities. If average annual capital expenditures exceed average annual depreciation expense, that signals the entity is replacing and adding to its asset base, which characterizes a growing entity. Per the Application, [redacted]. As shown in ***Table 5***, PYA was unable to independently calculate the reinvestment rate for periods beyond FY2022, as statements of cash flows quantifying capital expenditures were not provided by PCC and PCC [redacted]. But, in FY2020 and FY2021, PCC's capital expenditures approximated half of annual depreciation expense. This suggests that deferred capital and maintenance needs exist at the Hospitals.

  PACE loans are intended to be used for capital projects to improve PCC's infrastructure. [redacted]

- ***Cash Flow, Liquidity, and Leverage Metrics*** **–** As evidenced by the growing related party payable, the numerous vendor holds, negative financial impact of the cyber incident, and PCC's consistent reliance on PMH to fund operational shortfalls and capital expenditures, PCC's liquidity crisis continues to deepen. Certain financial ratios from PCC's FY2020 through FYTD March 31, 2024, financial statements are presented within ***Table 5***.

[6] This amount has not been separately disclosed in PCC's most recent unaudited financial statements.

Table 5

PCC

(Dollars in Thousands)	FY2020	FY2021	FY2022	FY2023^	FYTD 2/29/24^*	FYTD 3/31/24^*	Comments
Liquidity							
Unrestricted Cash & Cash Equivalents	$1,820	$0	$0				
Current Ratio	1.38	1.15	0.75				Higher is better
Days Cash on Hand	1.83	0	0				Higher is better
NWC % to Net Revenue	8.0%	3.4%	(6.2%)				Higher is better
Leverage							
Total Liabilities to Total Assets	80.6%	90.9%	110.0%				Lower is better
Profitability							
EBITDA Margin	(12.9%)	(1.7%)	(7.2%)				Higher is better
Capital Spending							
Capital Expenditures to Depreciation and Amortization Expense[1]	59.09%	40.31%	*NR*				Higher is better

^ *Unaudited*

* *The income statement has been annualized.*

[1] *Many assets were reclassed to held-for-sale status during FY 2022 and the calculated metric is no longer meaningful.*

NR Not reported

There has been little to no improvement in any ratios since the last audited financial statements (FY2022). In most instances PCC's performance, demonstrated by liquidity, leverage, and profitability ratios, has decreased since FY2020.

In summary, PCC has been dependent upon PMH since FY2020 to fund operational shortfalls and capital investments. PMH has engaged healthcare operational improvement firms to identify and attempt to implement improvement initiatives, but PCC remains unable to generate positive cash flow. Given current economic challenges facing acute care facilities, including but not limited to, increased labor expense, other inflationary pressures, and minimal reimbursement increases, PCC faces a daunting challenge to materially improve operations without significant additional volume and/or restructuring. Otherwise, PCC will continue to be dependent on third party funding to support its operations.

PMH KEY OBSERVATIONS

From FY2020 through FYTD March 31, 2024, PMH has experienced declining margins resulting in decreasing liquidity even after receiving $450 million in May 2023 from a master restructuring of its debt. As of March 31, 2024, PMH reported [redacted] days cash on hand and had [redacted].

- ***Key Operating Results and Balance Sheet Metrics*** – Although PMH's liquidity crisis is now acute, their financial instability has been growing for several years as demonstrated by the following items:
  - PMH has reported negative cash flow from operating activities starting FY2021 through FY2024 (annualized) totaling [redacted].
  - PMH reported negative EBITDA and negative net working capital beginning in FY2022 and FY2021, respectively.
  - Since FY2022, [redacted].

  Several factors contribute to these declining operational results during the historical period, including events characterized as non-recurring in nature such as a cyber incident in August 2023 and non-recurring governmental assistance under the CARES Act associated with the nationwide COVID-19 public health emergency. That stated, PMH's financial condition, absent CARES Act funding, raises questions regarding PMH's ongoing financial viability to support its subsidiaries, including PCC. The following information summarizes PMH's recent financial results since FY2020:

Table 6

PMH

(Dollars in Thousands)	FY2020	FY2021 (1)	FY2022 (1)	FY2023^	FYTD 1/31/24^*	FYTD 3/31/24^*
Income Statement						
Total Net Revenue	$2,733,388	$3,027,337	$3,178,712	[redacted]	[redacted]	[redacted]
Total Operating Expenses	2,836,702	3,074,152	3,329,934			
Net Operating Income (Loss) before grants and investments	(103,314)	(46,815)	(151,222)			
Net Income (Loss)	(99,610)	(143,345)	(233,229)			
EBITDA	95,598	33,286	(107,677)			
Balance Sheet						
Total Assets	$2,042,389	$1,815,167	$1,824,614			
Total Liabilities	3,102,004	3,089,557	3,282,755			
Total Stockholders Equity (Deficit)	(1,059,615)	(1,274,390)	(1,458,141)			
Net Working Capital Surplus (Deficit)	130,032	(250,102)	(346,364)			

(Dollars in Thousands)	FY2020	FY2021	FY2022	FY2023^	FYTD 1/31/24^*	FYTD 3/31/24^*
Cash Flow Statement				[redacted]	[redacted]	[redacted]
Cash from Operating Activities	$412,236	($172,212)	($145,885)			
Cash from Investing Activities	(4,670)	(45,497)	(45,963)			
Cash from Financing Activities	(72,833)	(64,959)	177,619			
Liquidity						
Total Cash	$386,824	$58,993	$56,084			
Available Line of Credit	*NR*	*NR*	*NR*			

^ *Unaudited*

* *The income statement has been annualized*

NR Not reported

(1) For consistent presentation purposes, PYA added back held for sale and discontinued operation amounts.

- ***Debt and Liquidity*** – PMH's liquidity position declined to increasingly alarming levels in the past 12-18 months. As noted in PCC's FY2022 audited financial statements, immediately prior to February 2023, PMH defaulted on two of its credit obligations, an ABL lending facility and a MPT agreement, resulting in PMH entering into forbearance agreements with these lenders in February 2023. These agreements were subsequently amended to extend the forbearance period until May 31, 2023. To obtain additional liquidity, PMH incurred debt and issued ownership to MPT, the landlord of several PMH real estate assets outside of Rhode Island, in lieu of payment for $68 million in delinquent rent and interest obligations.[7]

  According to a disclosure from MPT's June 30, 2023, Form 10-Q filed with the Securities and Exchange Commission, on May 23, 2023, PMH completed its recapitalization plan, which included receiving $450 million in new financing from several lenders, with the largest financier being MPT. This master restructuring agreement resulted in two loans totaling $400 million and a $50 million line of credit. In addition to issuing new credit capacity to PMH, MPT also obtained a non-controlling interest in PMH of approximately $654 million.[8] [redacted]

[7] From MPT's June 30, 2023, Form 10-Q filed with the Securities and Exchange Commission.

[8] Ibid.

[redacted].

Although PMH received a $50 million credit line in the May 2023 recapitalization, [redacted]

To lessen its financial obligations, PMH is currently soliciting buyers for all its east coast operations. During his SUO, George Pillari explained [redacted]

- ***Financial and Operational Metrics –*** Given PMH's deteriorating financial condition, PYA prioritized analyzing PMH reported financial metrics for the last two fiscals and FYTD. Of note, PMH has not provided audited financial statements for the FYE September 30, 2023. In months where PMH provided internal financial reports, certain financial ratios are presented within ***Table 7***.

Table 7

PMH

(Dollars in Thousands)	FY2022 (1)	FY2023^	FYTD 1/31/24^*	FYTD 3/31/24^*	Comments
Liquidity					
Current Ratio	0.72	[redacted]	[redacted]	[redacted]	Higher is better
NWC	($346,364)	[redacted]	[redacted]	[redacted]	
NWC % to Net Revenue	(10.9%)	[redacted]	[redacted]	[redacted]	Higher is better
Profitability					
EBITDA Margin	(3.4%)	[redacted]	[redacted]	[redacted]	Higher is better
Operating					
Operating Margin	(4.8%)	[redacted]	[redacted]	[redacted]	Higher is better

^ *Unaudited*

* *Based upon annualized income statement figures, where applicable.*

(1) For consistent presentation purposes, PYA added back held for sale and discontinued operation amounts for calculations.

Available Credit	FYTD 6/30/23	FY2023	FYTD 1/31/24	FYTD 3/31/24
Amount of unused credit (on each open line)[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[1] *Internally prepared and reported by PMH.*

For certain critical ratios used to assess financial stability, PMH reported alarming metrics; thereby raising questions about its likelihood for long-term profitability and success. Key observed metrics include:

- PMH's enterprise-wide reported days cash on hand ratio has been precariously low, representing enough cash to cover [redacted]. In PMH board minutes obtained as supplemental information to the Application, [redacted].
- Vendors typically require payment terms of 30 to 60 days. As of March 31, 2024, PMH's [redacted] These elongated payment cycles generally result in vendors unwilling to provide goods and services. In the case of hospital operations, this can result in lack of necessary supplies and services to provide appropriate patient care.

Given PMH's current financial situation, there are concerns about its ability and inclination to sustain PCC's continued operational shortfalls and fund PCC capital expenditures for the foreseeable future. Even if PMH manages to secure additional credit in the short-term to sustain cash flow, there are uncertainties about its long-term financial viability.

CENTURION AND NEW CHARTERCARE KEY OBSERVATIONS

Centurion's proposed transaction, inclusive of creating an independent New CharterCARE, carries execution and financial risk. The following identifies and discusses those assessed risks:

- ***Financing*** – We understand the transaction is contingent upon financing to support the purchase price and adequate cash on hand for the New CharterCARE. According to Barclays Managing Director, Joseph Hegner, during his SUO, [redacted]. Assuming $80 million in cash on hand at closing generated solely through the financing (PCC currently holds no cash on hand) and annualizing the PCC operating expenses for the first six months of FY2024, PYA calculates DCOH[9] will approximate [redacted] at closing, [redacted]. Should the financing be successful, there are additional concerning trends that would require immediate intervention to prevent continued cash diminution, such as:
  - *Net working capital* – The APA calls for a target net working capital of $0. Viable entities, especially new entities with anticipated losses at the outset, need a reasonable level of net working capital to support operations. VMG's valuation estimated normalized net working capital of 6% of net operating revenues, or approximately $22 million. We understand there is no other known source to fund incremental net working capital other than the $80 million in cash. Therefore, assuming sales proceeds are used to bring the net working capital balance to $0 at closing, at least [redacted] of the $80 million cash infusion will be necessary to "cover" working capital needs over the first 60-90 days of Centurion/New CharterCARE operations. Thus, cash available for capital expenditures, funding any ongoing operational losses, funding of debt service, and for liquidity purposes will be no more than [redacted].
  - *Transition costs* – With the exception of [redacted] for IT transition costs, Centurion has forecasted no one-time costs to affect the transition. In other transitions from integrated health systems to independent entities, PYA's experience suggests significant costs for transition activities are often incurred, including capital investments and operational expenses to purchase and implement IT applications, hardware, network, and infrastructure. Other examples of integration and transition expenses include costs associated with rebranding the system. No information has been presented, nor have any SUOs addressed, transition and/or integration expenses. To the extent such expenses are incurred, the amounts available to New CharterCARE for continued funding of operating losses, payment of debt service, investment in capital (including the previously discussed deferred capital and maintenance), and for investments in growth are further limited from the [redacted] amount referenced herein.
  - *Operating losses* – For the first six months of FY2024, PCC reported EBITDA and net income [redacted]. Centurion and New CharterCARE leadership believe their plans to improve financial results will be successful;

[9] DCOH calculated as Cash/(Total Operating Expenses less Depreciation and Amortization/365).

however, such initiatives often require time to materialize. Furthermore, New CharterCARE is expected to [redacted] These assumptions suggest New CharterCARE will experience cash needs, in excess of cash provided through operations, exceeding [redacted] per day during the periods immediately following closing.

- *Capital expenditures* – PCC's annual capital budgets for FY2023–FY2025 provided in the Application range from approximately [redacted] Of note, Centurion's EBITDA Bridge calls for Year 1 EBITDA of approximately [redacted], leaving [redacted] in Centurion projected cash from operations to fund capital expenditures. Should the capital needs of the facilities be closer to the [redacted] estimates provided by PCC, the funding for the capital needs in [redacted] in forecasted cash flow would have to be drawn from the initial cash investment cited herein.

In addition to likely DCOH debt covenants, DSCR covenant requirements are typical and should be anticipated. Based on Centurion's EBITDA Bridge, if the New CharterCARE can generate annual EBITDA of approximately [redacted] (see notes below regarding the risks of achieving these results) [redacted], Centurion will be capable of generating a DSCR of [redacted]. That calculation is very sensitive to changes in assumptions. For instance, if either EBITDA or investment earnings [redacted]. Considering that 1) the EBITDA Bridge assumes a $41 million increase in EBITDA in Year 1 (equivalent to a 10.9 percentage points, or 1,090 basis points, increase in operating margin) and 2) [redacted] (although, as previously mentioned, a significant portion of the $80 million cash infusion from the sale would likely go to fund working capital and ongoing operations and thus be unavailable for investment), New CharterCARE is unlikely to achieve Centurion's target DSCR in Year 1.

Centurion also plans to obtain tax-exempt debt, which will require the CCHRI entity to be certified by the IRS as a 501(c)(3) tax-exempt entity. We understand this certification is required prior to financing for the non-taxable debt. If the IRS does not certify the entity as a 501(c)(3) in time to proceed with the financing process, [redacted].

- ***Valuation*** – As previously mentioned, the financing assumptions include a $160 million fair market value for the business enterprise of New CharterCARE, which was on the high end of the $139 million to $161 million value range provided by VMG. Centurion's analysis of the transaction amounts and structure is based on the VMG valuation, which is dated February 14, 2023, more than 15 months old at the time of our Report. Much has changed since that date, leading to deteriorated PCC and PMH results, which calls into question the ability for Centurion to finance the $160 million at the terms assumed within the plan. Furthermore, the management forecast provided to VMG for the valuation has changed within the latest EBITDA Bridge, and there is no longer an assumption that a management company will be involved in the turnaround and management of New CharterCARE. Accordingly, reliance on this valuation is questionable as a basis for the financing assumptions.

- ***Realizing full efficiencies of Centurion's EBITDA Bridge*** – Centurion provided an EBITDA Bridge projecting Year 1 improvements of $41 million resulting from [redacted] initiatives. This equates to an improvement in operating margin of approximately 10.9 percentage points, or 1,090 basis points, in one year. PMH had previously engaged Ovation and A&M to affect operational improvements but [redacted]. However, Centurion asserts the New CharterCARE can accomplish this significant operational improvement while simultaneously affecting a complex transition plan to an independent system. As we reviewed the EBITDA Bridge, we identified several assumptions which call into question the reasonableness that New CharterCARE will realize the entirety of the improvement initiatives, forecasted for Year 1 including but not limited to:
  - No support was provided in the EBITDA Bridge nor SUOs for estimated [redacted]. Therefore, the probability of these efficiencies is far from certain.
  - There is very little support for the assumed [redacted] efficiency. Based on the information provided, this efficiency appears to be focused on [redacted] Furthermore, Centurion documents in its Transition Plan that the following core business functions must shift from enterprise-level PMH oversight and staffing to the local market, yet no quantitative analysis has been provided which contemplates the variance in historical PMH expenses for these functions compared to rebuilding those functions individually in Rhode Island:
    - Vendor agreement negotiation and relationship management
    - Payer agreements
    - IT systems, support, and planning (Applications, Security, HelpDesk)
    - Compliance functions
    - Policy and procedure development
    - Treasury/cash management
    - Annual budgeting process
    - Revenue cycle software/services
    - Enterprise strategic planning

- Facilities/construction management
- Physician billing
- Selection of staffing agencies
- Employee recruitment processes
- Workforce productivity target setting

Absent detail provided by Centurion to support their assessment that they are "improving the financial performance by reducing corporate overhead," it is questionable whether the assumed amount associated with these efficiencies will materialize.[10]

- Several [redacted] initiatives, including [redacted] However, each of these initiatives require [redacted]. There is no evidence any of these costs have been considered in the EBITDA Bridge, [redacted]. Therefore, it is questionable if the levels of hospital EBITDA, [redacted], will generate the improvements in Year 1.
- Incremental expenses to [redacted] was not factored into the analysis.
- Per Jeff Liebman's SUO, [redacted] yet those costs are not included in the EBITDA Bridge.

As previously mentioned, the DSCR for New CharterCARE is sensitive to changes in cash flow available for debt service. Therefore, the New CharterCARE improvement initiatives must be implemented immediately and provide immediate improvements to cash flow in order for [redacted].

- ***Timely, effectively and completely implementing Centurion's Transition Plan*** –Centurion provided a Transition Plan that helps guide the New CharterCARE's path to independence. It addresses the key processes, people, and information systems which must be migrated from PMH's corporate shared services platform to the local entities. However, the investments necessary to implement the Transition Plan are not identified. Costs associated with new information systems, human resources (e.g., recruiting, onboarding, training dozens of new positions), and entering into new local contracts are not identified and the costs could be material.

  Additional information pertaining to these Transition Plan challenges include:

[10] From Centurion's Transition Plan, page 4.

- Although PCC's existing EMR and ERP will remain and continue to be utilized, there are several applications noted in the Transition Plan which require transition to local agreements and/or new vendors, which can lead to incremental costs and business disruptions during migrations.
- Reconstituting the core business functions outlined above can be a long and arduous process. Centurion or current PCC leadership have been unable to provide specifics regarding the costs for these initiatives or how they will find/recruit the skilled labor to support these functions.
- Payer relations are instrumental to ensuring continuity of reimbursement during a transition, and much work is required to obtain consent from managed care and commercial payers to assign existing contracts to, or negotiate new contracts for, New CharterCARE. Presently, Centurion has forecasted no change in reimbursement rates from current PCC experience. Given that Centurion is only purchasing assets, and therefore not assuming the hospitals' NPIs, Centurion will need to ensure new NPIs are credentialed with these managed care and commercial payers, which could result in delays in reimbursement.
- The Change in Ownership application, which is required to bill governmental payors, takes time to process. These procedures often lead to a delay in reimbursement from governmental payers, post-closing. Of note, governmental payers (Medicare and Medicaid) accounted for approximately 68.5% and 70.3% of FY2023 net revenue for RWMC and OLF, respectively.

- ***Transitional Services Agreement*** – The Transition Plan alludes to several services (including access to existing PMH contracts) which require PMH's continued support post-closing. These include [redacted] However, no draft TSA has been provided as a part of the Application. Therefore, the costs associated with PMH's continued provision of these services/applications is not presently quantifiable. Of note, neither the Transition Plan nor the EBITDA Bridge present the costs for the services provided pursuant to the TSA. Additionally, given the liquidity crisis presently experienced by PMH, there is risk that PMH will not be able to maintain operations for the period of the TSA until New CharterCARE can establish all these services/applications locally.
- ***Management's Experience and Ability to Affect the Transition*** - Centurion has no experience operating acute care hospitals and has not partnered with an experienced hospital management company to operate New CharterCARE. Therefore, Centurion is relying upon the existing PCC management team to operate the independent non-profit entity post-closing. That same management team has presided over the PCC operations that have produced recent operating losses. Implementing the proffered Transition Plan will be difficult, as has been described herein. Additionally, the management team will be simultaneously implementing the initiatives in the EBITDA Bridge to accomplish the necessary financial turnaround. Effectively implementing these plans successfully will require significant operational changes. No evidence has

been provided that this management team is equipped to accomplish these tasks. The PCC CEO, Mr. Liebman, [redacted]. In his response, Mr. Liebman stated, [redacted] Effective integration of financial management with operational efficiencies will be necessary to accomplish such a significant financial improvement plan.

- ***Additional Funding Alternatives*** – If the funding contemplated by New CharterCARE is not sufficient to support working capital, fund operational losses, invest in necessary capital, and affect the transition, options to obtain additional capital have not been identified. Centurion has said it has no plans to fund New CharterCARE and will not guarantee the debt. Given the valuation presently relied upon by Centurion, there does not appear to be additional value from which to obtain incremental financing. Absent other intervention (e.g., the state), New CharterCARE will have limited options to support operations if the Transition Plan and financial improvement plans in the EBITDA Bridge are not accomplished.

SUMMARY

Unfortunately for the citizens of Providence and North Providence served by RWMC and OLF, neither option before RIDOH of 1) approving the Application to establish as a newly formed, non-profit, stand-alone New CharterCARE or 2) denying the Application whereby PCC will continue under PMH's management, provide reasonable confidence of short-term financial viability for the hospitals.

Over the last four fiscal years, PCC has been unable to generate positive cash flow from operations, absent the non-recurring Provider Relief Funds from the federal government during the COVID-19 pandemic, and has remained dependent upon its parent organization, PMH, to fund operational shortfalls and capital expenditures. Even with this history, the Application asserts that New CharterCARE can be financially viable once converting to a stand-alone, non-profit health system. As discussed herein, we have significant concerns associated with New CharterCARE's ability to successfully affect this transition and achieve the financial improvement necessary to sustain operations. Those identified challenges become moot, though, if Centurion and New CharterCARE cannot secure adequate financing to consummate the Transaction.

We have observed through our analyses that both PCC and its parent, PMH, face short-term financial viability challenges. Those combined challenges may ultimately lead to a business decision by PMH to exit the Rhode Island market at any time PMH feels the situation is untenable with no foreseeable successor organization for the Hospitals. [redacted]

These challenges to the continued financial viability of the Hospitals jeopardize the healthcare access for Rhode Island residents who depend on current PCC health services, including those populations who are traditionally underserved. Prior solutions for these Hospitals, including PMH ownership, have been challenged. Unless additional solutions are identified, RIDOH and the state of Rhode Island face the very real possibility these Hospitals are at high risk of failure.

APPENDIX A:
SCOPE OF WORK

Scope of Work
Project Initiation
Conduct kick-off call with relevant individuals of RIDOH to ensure RIDOH's objectives are clearly understood and to confirm timeline, process for interviews with the Transacting Parties, and form of anticipated deliverables.
Assist RIDOH, as requested and at their direction, in assessing whether initial financial information provided by the Transacting Parties satisfies RIDOH's requirements to deem the Initial Application complete.
Issue information request to obtain data and information not yet provided by the Transacting Parties.
Understand Key Terms of the Proposed Transaction
Obtain an overview of the Transacting Parties' organizational structure before and after the Proposed Transaction.
Read the agreement pertaining to the Proposed Transaction between the Transacting Parties to gain an understanding regarding the general terms, conditions, and commitments agreed to between the Transacting Parties.
After understanding the terms of the transaction agreement and existing financial statements of the Transacting Parties, document observations related to potential financial implications which the Proposed Transaction may have on the statutory review criteria of the Hospital Conversions Act.
Analyze Current Financial Performance of PCC
Obtain and comment on the FY 2020 through FY2022 annual audited financial statements of the Transacting Parties' legal entities (as available).
Obtain and comment on the twelve most recent internal monthly financial statement packages. If available, this analysis will be of the individual legal entity (e.g., hospital level) financial information.
Comment on significant estimates noted in the Transacting Parties' audited financial statements for the prior three annual periods and the current year-to-date (collectively, the "Historical Period").
Obtain and comment on any of the Transacting Parties' budget-to-actual reports for the Historical Period. *(NOTE: PYA was unable to complete this work step as operating budgets were not provided by the Transacting Parties.)*
Inquire and comment on the following items related to the Transacting Parties' banking relationships during the Historical Period, including: Banking agreements; Borrowing terms and debt covenants; Credit facilities; Debt covenant compliance; and Outstanding indebtedness.

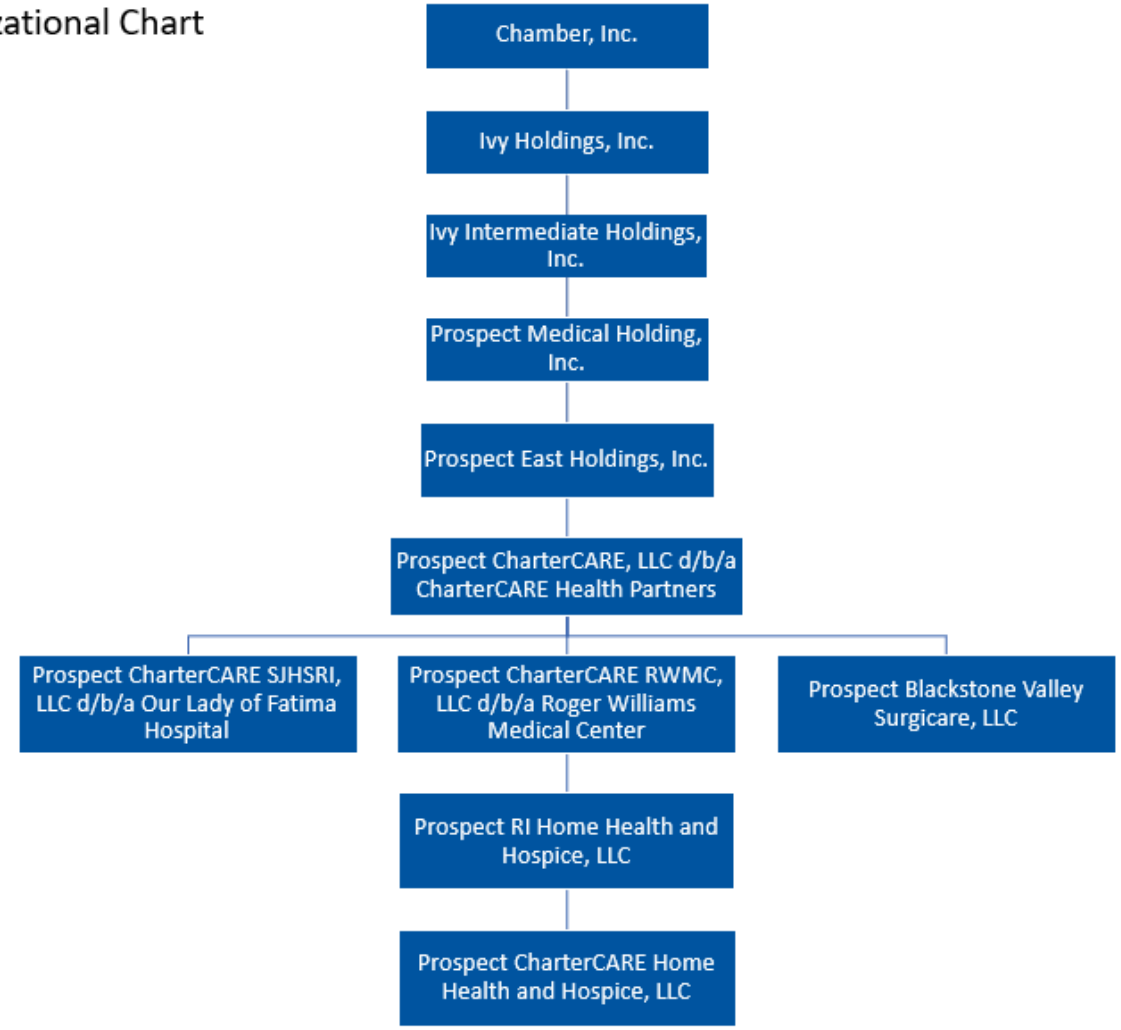
Scope of Work
(NOTE: PYA only received a redacted version of the MPT MRA. Additionally, PYA did not receive the FY2023 audited financial statements. As such, PYA was unable to complete this work step as supporting documentation was not provided by the Transacting Parties.)
Obtain and comment on materials related to the Transacting Parties' historical trends in revenues and earnings during the Historical Period, including: Net operating revenue; Charity care; Volume metrics; Payer mix; Net operating income; and EBITDA (as applicable).
Prepare annual trending analysis for select financial ratios (liquidity, profitability, and solvency) and metrics of the Transacting Parties compared to benchmarks, as available and applicable, during the Historical Period.
Obtain and comment on any financial budgets/forecasts and budgeted operating metrics of the Transacting Parties. *(NOTE: PYA was unable to complete this work step as operating budgets were not provided by the Transacting Parties.)*
Note observations from provided materials on other agreements that have restricted the use of the Transacting Parties' assets. *(NOTE: PYA was unable to complete this work step as supporting documentation, including updated audited financial statements, was not provided by the Transacting Parties.)*
Comment on key balance sheet trends which may relate to liquidity and leverage trends of the Transacting Parties, including: • Cash and cash equivalents; • Investments (restricted and unrestricted); • Inventory; • Accounts receivable; • Property, plant, and equipment; • Goodwill; • Accounts payable; • Other accrued liabilities; • Interest-bearing debt; and • Other long-term liabilities.
Inquire of and comment on the Transacting Parties' significant commitments or contingent liabilities, including: • Pending or threatened litigation; • Investigations by regulatory or other authorities; • Self-insurance liabilities; and • Post-retirement benefits. *(NOTE: PYA was unable to complete this work step as FY2023 audited financial statements were not provided by the Transacting Parties.)*
Analyze the impact of CARES Act stimulus funds and loans on the Transacting Parties' liquidity and operational results;

Scope of Work
Analyze spending on capital improvements over the Historical Period;
Comment on the Transacting Parties' ability during the Historical Period to support its capital needs through cash flow generated from operations.
Assess the financial capabilities of Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital, Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center, The Centurion Foundation, Inc., QHR Health, LLC and any consulting/management companies involved with this transaction. *(NOTE: no analysis was performed on QHR Health, LLC as the entity is no longer a Transacting Party on the Application.)*
Observe and comment on any deficiencies or areas of non-compliance related to financial operations or internal controls over financial reporting, as noted in audited financial statements and/or management letters from auditors for the Transacting Parties during the Historical Period.
Obtain and comment on a schedule of the Transacting Parties' capital spending over the past three fiscal years compared against historical levels of depreciation and relevant benchmarks.
Obtain and comment on the Transacting Parties' provided capital budgets for future periods.
Interviews of Relevant Parties
Preparation of interview questions.
Upon request by RIDOH, attend up to 10 statements under oath with selected management members of the Transacting Parties relevant to PYA's scope as detailed herein.
Preparation and Provision of Report
Document in a written report, key observations from completion of our scope of work for RIDOH's use in its assessment of the Transacting Parties' application.
Presentation to Rhode Island Health Services Council
Prepare and deliver presentation of key observations from our scope of work to the Health Services Council at the conclusion of the engagement. This presentation will be provided remotely and will not require travel to Rhode Island for an in-person meeting.

Scope of Work
Communication with RIDOH
Throughout the engagement, provide weekly updates to RIDOH leadership on the progress of the analysis, any complicating issues in completing the scope of work, updates to timeline, and sharing of significant observations.

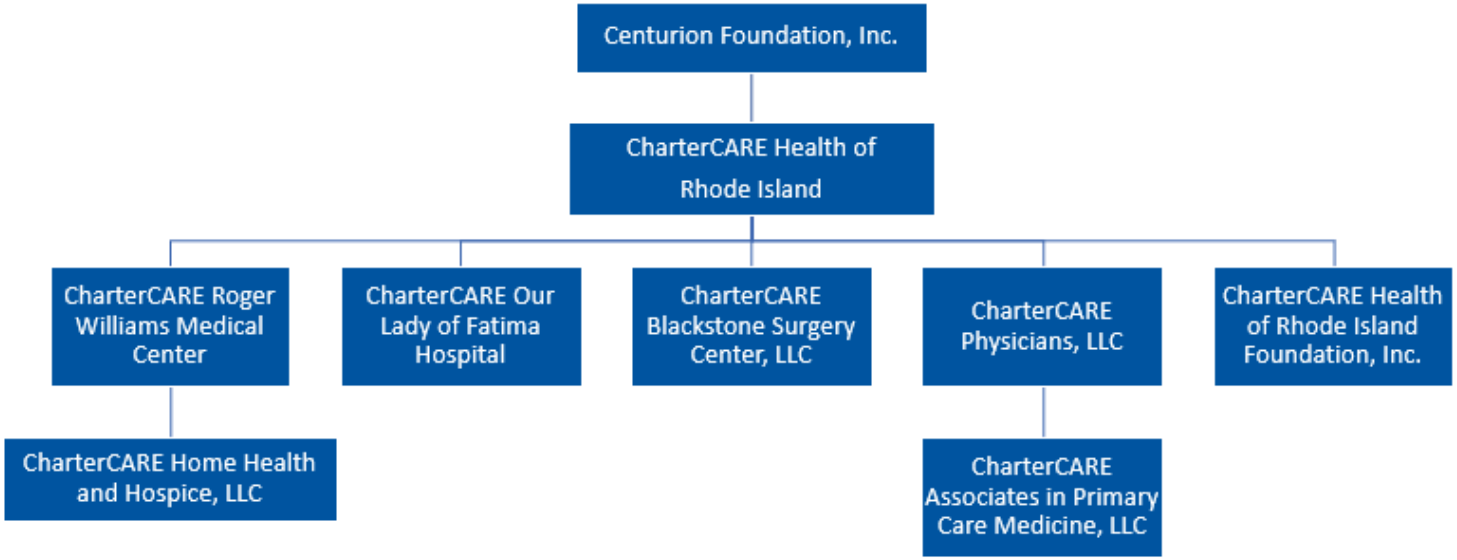
APPENDIX B:
ORGANIZATIONAL CHART PRIOR TO CONVERSION

Pre-Transaction Organizational Chart



APPENDIX C:
PROPOSED ORGANIZATIONAL CHART SUBSEQUENT TO CONVERSION

Post-Transaction Organizational Chart



Appendix B

REVIEW OF THE PROPOSED CONVERSION OF ROGER WILLIAMS MEDICAL CENTER, OUR LADY OF FATIMA HOSPITAL, AND THEIR AFFILIATES BY THE CENTURION FOUNDATION, INC.:

IMPLICATIONS FOR HEALTH CARE QUALITY, SAFETY, AND ACCESS

Review performed for the Rhode Island Department of Health, March through June 2024

Consulting team:

Patrick S. Romano, MD MPH

Monika Ray, PhD

Irina Tokareva, MAS CPHQ RN

Background

The material contained herein is a report to the Rhode Island Department of Health for the purposes of assessing the quality, safety, and accessibility of health care services provided by the two organizations (Roger Williams Medical Center and Our Lady of Fatima Hospital) that will comprise the New CharterCARE System, following the proposed conversion from Prospect Medical Holdings, Inc. to The Centurion Foundation, Inc. This review was conducted pursuant to the Hospital Conversions Act (HCA), Rhode Island General Laws (RIGL) Title 23, § 23-17.14-8, which stipulates the following review criteria:

(1) Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties, are satisfactory;

(2) Whether sufficient safeguards are included to assure the affected community continued access to affordable care;

(3) Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;

(4) Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

(5) Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;

(6) Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;

(7) Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access, and balanced healthcare delivery to the residents of the state; and

(8) Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval for any previous conversion pursuant to an application submitted under § 23-17.14-6.

Given my qualifications and experience, as described below, my review focused on criteria (1), (2), and (7). Because the proposed owner of the facilities involved, The Centurion Foundation, Inc., has no prior experience operating hospitals and no established competence or community standing in this domain, my review focused on the current officers and staff of Prospect CharterCARE LLC, and the current operation of Roger Williams Medical Center and Our Lady of Fatima Hospital. The proposed conversion will transfer the existing facilities and the existing Rhode Island-based leadership and staff to the new entity, labeled New CharterCARE System. Therefore, it is appropriate to evaluate the condition and experience of the existing facilities, with their current staff, to better understand "whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties, are satisfactory."

My qualifications can be summarized briefly as follows. I am a practicing physician and a Professor of Medicine and Pediatrics at the University of California Davis (UC Davis) School of Medicine in Sacramento, California. I am a graduate of Princeton University (A.B.), Georgetown University School of Medicine (M.D.), and the University of California, Berkeley School of Public Health (M.P.H.). I completed combined residency training at Case Western Reserve University Hospitals in Cleveland, Ohio, and fulfilled the requirements for board certification in both internal medicine and pediatrics. After residency training, I completed a fellowship in health services research at UC San Francisco Institute for Health Policy Studies.

Much of my research program over the past 30 years has focused on developing, refining, applying, and validating quality measures, especially related to inpatient care. In numerous studies, I have evaluated methods for comparing hospital quality, while adjusting for patients' severity of illness, and explored the validity of using various sources of data to measure adverse events such as complications of care and readmissions. These research efforts have resulted in approximately 230 peer-reviewed publications, 15 book chapters, and 40 editorials and related publications. I am currently working on multiple projects supported through grants and contracts from the US Agency for Healthcare Research and Quality (AHRQ) and other agencies. For example, I currently serve as co-Editor-in-Chief of AHRQ's Patient Safety Network, which is the US Government's foremost tool for curating and disseminating information about patient safety in health care, including weekly news items, primers, cases and commentaries, and continuing education spotlights. I also serve as Clinical Lead for the AHRQ Quality Indicators program, in collaboration with Mathematica.

As a result of my expertise in healthcare quality evaluation, I have served in numerous consulting and technical assistance roles to global, national, and regional health agencies, including the California Department of Public Health, Department of Corrections and Rehabilitation, Office of Statewide Health Planning and Development (now Department of Health Care Access and Information), and Office of the Patient Advocate; AHRQ; the US Centers for Disease Control and Prevention (CDC); the Centers for Medicare & Medicaid Services (CMS), and the international Organization for Economic Cooperation and Development (OECD). I have also participated in or led expert panels for The Joint Commission, the National Quality Forum, the National Committee for Quality Assurance, OECD, the World Health Organization, CMS, the University HealthSystem Consortium (now Vizient), the Leapfrog Group (an employer coalition that promotes transparency and quality improvement in health care), the American Medical Association's Physicians Consortium for Performance Improvement, and the California Association of Public Hospitals/ Safety Net Institute. For example, I serve on the Scientific Methods Panel for the National Quality Forum, now Battelle's Partnership for Quality Measurement, the Perinatal Care Technical Advisory Panel for The Joint Commission, Leapfrog Group's Expert Panel on Hospital Safety Scoring, and the National Committee on Vital and Health Statistics Workgroup on Timely and Strategic Action to Inform ICD-11 Policy. I recently completed a term of service on the National Advisory Council for Healthcare Research and Quality, and its Subcommittee on Healthcare Quality Measurement.

I have previous experience evaluating the quality implications of hospital mergers and conversions, having consulted extensively for the Federal Trade Commission and the Rhode Island Department of Health regarding previous hospital mergers, acquisitions, or conversion applications. I have simultaneously maintained an active practice in both internal medicine and pediatrics for 34 years. As an active member of the UC Davis Medical Group, I spend 10-15% of my time providing clinical

care at UC Davis Health in Sacramento, California. I have previously served on my departmental quality improvement committee, and as the Medical Director for Patient Safety Research in UC Davis Health. In the latter capacity, I advised the Chief Medical Officer and Chief Quality Officer on quality improvement strategies and facilitated internal research and evaluation of quality improvement interventions.

I was assisted in this review by:

- Monika Ray, PhD, is a computer scientist and machine learning specialist who brought extensive experience using both claims-based data and electronic clinical quality measure data in developing, testing, and refining AHRQ Quality Indicators and CMS Patient Safety Indicators, with a special focus on predictive analytics, including feature selection and model development and validation. Her skills and experience analyzing commercial and Medicare claims data, state hospital discharge data, registry data from the California Coronary Artery Bypass Graft Outcomes Reporting Program, and chart-abstracted data from the AHRQ/CMS Quality and Safety Reporting System, and then triangulating findings from these analyses with findings from documents and site visits, was invaluable to my review.
- Irina Tokareva, MAS, CPHQ, RN, is a registered nurse and quality improvement specialist who holds a master's degree in advanced studies in Healthcare Administration, a Certified Professional in Healthcare Quality, and Green Belt Six Sigma certification. She has over 18 years of experience in quality improvement, clinical outcomes measurement and data analysis, medical/health education, patient safety, and regulatory compliance. Her skills and experience reviewing hospital survey findings, plans of correction, quality improvement plans, and other documents was invaluable to my review.

My review is divided into five parts, as follows:

1. Contribution (of the facilities involved in the proposed conversion) to the Rhode Island health care system. This part focuses on the role of the transacting parties in providing "essential medical services" to the state's population, including traditionally underserved populations.
2. Current facilities and equipment. This part focuses on whether the transacting parties have the facilities and equipment necessary to continue providing "safe and adequate treatment, appropriate access, and balanced healthcare delivery" to the residents of Rhode Island.
3. Current quality and safety performance. This part focuses on whether the transacting parties have demonstrated (through their recent performance) "the character, commitment, competence, and standing" needed to continue providing "safe and adequate treatment, appropriate access, and balanced healthcare delivery" to the residents of Rhode Island.
4. Current quality and safety processes. This part addresses the transacting parties' plans to continue providing "safe and adequate treatment, appropriate access, and balanced healthcare delivery" to the residents of Rhode Island.
5. Recommendations Pursuant to RIGL Title 23, §23-17.14-8 to Ensure Safe and Adequate Treatment, and Appropriate Access to healthcare services during and after the proposed hospital conversion.

The activities undertaken as part of this review included:

1. Reviewing the Centurion-Prospect HCA application and supplemental materials;
2. Listening to the Centurion-Prospect HCA application public meetings, and reading written public comments relevant to my review;
3. Analyzing hospital discharge data from all hospitals in Rhode Island, and applying publicly available Medicare Severity Diagnosis Related Group (MS-DRG) software and AHRQ Quality Indicators software;
4. Reviewing all publicly available quality measures from the transacting parties, including all measures reported by CMS (data.medicare.gov or "HospitalCompare"), The Joint Commission, and Leapfrog Group;
5. Reviewing all citations and RIDOH surveys of Roger Williams Medical Center and Our Lady of Fatima Hospital, with plans of correction, over the past 5 years;
6. Meeting on several occasions with RIDOH staff and consultants;
7. Visiting and touring both Roger Williams Medical Center and Our Lady of Fatima Hospital on May 29, 2024; and
8. Meeting with and questioning key leadership from the transacting parties, including:
    a. Chief Executive Officer, Jeffrey H. Liebman
    b. Chief Operating Officer, Donna Rubinate RN MBA
    c. Chief Nursing Officer, Lynn Leahey RN
    d. Chair, Department of Medicine, John Stoukides, MD ScD
    e. Director of Safety and Security, Frank Castellone
    f. Director of Engineering and Maintenance, Neal Laughlin.

Based on my review of all available material, my team's analysis of publicly available data, my recent visits to both hospitals and meetings with key personnel, my role and experience as an expert consultant, and my review of the statutory requirements for Hospital Conversion, my opinion is that the transacting parties are able to meet the statutory review criteria identified in RIGL Title 23. Health and Safety § 23-17.14-8, as related to the quality, safety, and accessibility of healthcare services. I have identified several conditions that should be considered to ensure that the Centurion Foundation, Inc., and the New CharterCARE System are well positioned, after the proposed conversion, to continue providing "safe and adequate treatment, appropriate access, and balanced healthcare delivery to the residents of the state."

Part 1: Contribution to Rhode Island Health Care System

We used all-payer hospital discharge data from the Rhode Island Department of Health (RIDOH), which include the dates of admission and discharge for each inpatient episode from January 2016 through December 2022, to assess occupancy, service line volume, and market share at the two hospitals owned by Prospect Medical Holdings (Prospect), relative to the statewide market for inpatient services. Bed occupancy is traditionally calculated at midnight, reflecting the number of patients who are staying overnight in the hospital. Because patients are often admitted from the emergency department (ED) after midnight, but are only discharged after midnight if they expire, bed occupancy often rises through the early morning hours. During each 24-hour daily cycle, bed occupancy typically peaks in the late morning hours, as elective surgical patients leave the operating rooms to occupy hospital recovery beds, but before most of the day's discharges to home have been completed.

We corroborated these findings by analyzing more recent extracts of data reported by the Prospect hospitals to the Department of Health and Human Services' PROTECT database (https://healthdata.gov/Hospital/COVID-19-Reported-Patient-Impact-and-Hospital-Capa/anag-cw7u/about_data) from November 13, 2023 through April 30, 2024. We obtained additional contextual information during visits to the Prospect hospitals on May 29, 2024. These analyses focused on the contribution of Prospect hospitals to the Rhode Island health care system, and whether the services currently provided by these hospitals could be readily transferred to other hospitals in the event that the Prospect hospitals are unable to continue operating.

FINDINGS

Roger Williams Medical Center is licensed for 220 beds, reported 153 beds in use in 2021, and reports about 100-106 beds in use in recent months. Our Lady of Fatima Hospital (OLF) is licensed for 312 beds, reported 180 beds in use in 2021, and reports 128 beds in use in recent months. Both hospitals are staffing well below their licensed capacity. As a result:

- Both hospitals have entire units that are not currently open; these units provide auxiliary work space for housestaff (at Roger Williams) and storage space for outdated equipment.
- Both hospitals are able to offer single-bed rooms to the great majority of non-critical care patients, improving patient privacy and decreasing the risk of nosocomial transmission of pathogens such as *Clostridioides difficele*.

Occupancy at both hospitals has been relatively stable from 2016 through April 2024. For example, over the period from mid-November 2023 through April 2024, Roger Williams filled a mean (median) of 82.8 (82) beds, and OLF filled a mean (median) of 110.2 (110) beds. Therefore, both hospitals are operating efficiently, in the range of 80-90% of their currently staffed capacity. Over a longer timeframe going back to 2021 and 2022, Roger Williams was operating at 70% (2022 median) to 78% (2021 median) of its currently staffed capacity, while OLF was operating at 62% (2022 median) to 71% (2021 median) of its currently staffed capacity.

Evaluation of service lines, applying the Medicare Severity Diagnosis Related Group (MS-DRG) system to all inpatient discharges from 2016 through 2022, indicate that the major service lines (>5%) at Roger Williams include:

- Medical admissions for respiratory diseases (10.6%-11.5%)
- Medical admissions for circulatory diseases (7.7%-8.4%)
- Medical admissions for digestive diseases (6.1%-6.7%)
- Surgical admissions for metabolic diseases (7.9%-8.5%)
- Medical admissions for mental disorders (7.7%-9.1%)
- Medical admissions for alcohol and drug use and disorders (12.8%-15.6%)

Similarly, the major service lines (>5%) at OLF include:

- Medical admissions for nervous system diseases (7.2%-8.1%)
- Medical admissions for respiratory diseases (9.2%-10.6%)
- Medical admissions for circulatory diseases (8.8%-8.9%)
- Medical admissions for digestive diseases (4.1%-5.1%)
- Surgical admissions for musculoskeletal diseases (8.8%-9.2%)
- Medical admissions for infectious and parasitic diseases (6.6%-7.3%)
- Medical admissions for mental disorders (22.4%-22.7%)

In terms of market share, there are multiple service lines in which the Prospect hospitals provide at least 10% of statewide volume, indicating that these hospitals continue to play a vital role in the Rhode Island hospital market (and their current volume cannot easily be absorbed by other hospitals in Providence or its immediate vicinity). For example, Prospect hospitals provide:

- 9.6% to 15.2% of medical admissions across most major categories including respiratory, circulatory, digestive, hepatobiliary, musculoskeletal, endocrine and metabolic, kidney and urinary tract, hematologic, myeloproliferative, and infectious diseases;
- 8.6% to 16.8% of surgical admissions for digestive, hepatobiliary, musculoskeletal (orthopedic), kidney and urinary tract (urologic), and infectious diseases;
- 38.3% (2021) to 44.7% (2022) of inpatient surgery for nutritional and metabolic diseases (e.g., bariatric surgery); and
- 21.5% (2021) to 21.7% (2022) of inpatient mental health treatment, and 25.2% (2022) to 27.0% (2021) of inpatient treatment for alcohol and drug use and disorders.

My conclusion from these findings is that Prospect hospitals continue to play an important role in the Rhode Island health care system, that their volume cannot be readily absorbed by other hospitals in Providence or its immediate vicinity, and that there is clear need for these hospitals to continue to operate for the foreseeable future (although additional integration of clinical services may be necessary to optimize efficiency and limit capital outlays).

My review of public comments from over 100 stakeholders confirms that Prospect hospitals have an important and essentially irreplaceable role as providers of non-trauma physical and mental health services in the Providence and North Providence communities, with high proportions of patients from traditionally underserved communities. These hospitals have particular strengths in inpatient behavioral health and addiction treatment, cancer care (including cancer screening,

surgical oncology, and stem cell and other advanced treatments for hematologic malignancies), wound care (including hyperbaric oxygen therapy), bariatric surgery, multidisciplinary geriatric care (including geriatric oncology), and elective orthopedic and urologic surgery. Physicians, nurses, and other licensed professionals affiliated with Roger Williams and OLF evince strong confidence in the hospitals' current local leadership.

Accordingly, I was pleased to find that the conversion application describes no plans to terminate health care services currently provided by Prospect CharterCARE LLC, or to modify the accessibility of these services to traditionally underserved populations. However, it must be recognized that the current financial condition of Roger Williams Medical Center and Our Lady of Fatima Hospital make it likely that some changes in the availability of health care services, at either or both locations, may be necessary at some point in the future. Such changes, if they were to occur, would be likely to affect access by traditionally underserved populations, given the location and historical practices of the facilities. To the extent that the New CharterCARE System will have access to new revenue sources (e.g., charitable contributions) and reduced expenses in certain domains (e.g., taxes, drugs covered by 340b), such future changes in the availability of services may be less likely to occur if the conversion application is approved.

Part 2: Current Facilities and Equipment

We reviewed documents provided by the parties to this proposed conversion, visited both hospitals on May 29, 2024, attended or reviewed transcripts of town hall meetings, and informally interviewed key personnel in conjunction with our site visits. These information sources were triangulated to confirm relevant findings, so that each finding was corroborated by at least two sources. Our analyses focused on the current physical condition of the Prospect hospitals and the equipment contained therein, the extent to which the current physical condition of the hospitals is affecting quality and safety of care, and the quality and safety implications of transferring the hospitals in their current condition to the Centurion Foundation and the New CharterCARE System without further capital investments.

FINDINGS

Site visits, review of documents, and interviews with key personnel identified evidence of deferred maintenance in several key areas of both hospitals:

- Both hospitals have multiple roof leaks, which have been repeatedly patched or addressed through improvised systems to catch and divert water that enters the building into buckets, which must be monitored and emptied after each major rainfall. Although these improvised repairs appear to have averted visible damage in active patient care areas, the risk of contaminated water dripping onto patients or patient care equipment, structural damage to suspended ceilings, and mold infiltration has not been eliminated.
- The emergency department at OLF is overdue for comprehensive renovation, with a crowded waiting room, damaged flooring, 21 treatment bays that offer very little privacy for discussion of sensitive topics and little room to maneuver bedside equipment, and configurations that limit "line of sight" monitoring from the central nursing station.
- At least one chilling tower at Roger Williams appears to be nonoperational, with a temporary replacement unit in place. Although the replacement unit is reportedly meeting the current need, it is noisy. A condenser fan motor in the cooling system at OLF is also nonoperational, with delays in obtaining replacement parts, such that two portable air conditioning units have been put into place for use on warm days. The Project Description plan from OLF (C-CNT-PMH-021995) confirms that multiple air handling units (AHUs) at OLF are overdue for replacement.
- Both hospitals have outdoor parking lots with significant potholes and other surface irregularities, suggesting that complete resurfacing may be overdue.

In addition, site visits, review of documents, and interviews with key personnel identified evidence of deferred upgrades of equipment or essential services in several key areas of both hospitals:

- Imaging equipment overdue for replacement includes a computed tomography (CT) scanner from approximately 2008 at Roger Williams, and a nonfunctioning magnetic resonance imaging (MRI) machine at OLF. A portable, leased unit is currently in place at OLF to meet their immediate needs.
- Some nuclear medicine equipment at Roger Williams must be updated to meet the needs of an accredited cancer center.

- Most or all beds currently in use outside intensive care areas do not include built-in nurse call lights or alarms, and do not offer modern capabilities for handling obese patients and patients who are at high risk for pressure injury, requiring specialized surfaces and frequent repositioning. Patients are at risk of falling, and potentially sustaining significant injuries, when nurse call lights and bed alarms are disconnected or not operational, although currently reported fall rates from the National Database of Nursing Quality Indicators (Press Ganey) are within the expected range.
- The legacy Meditech electronic health record system has not been updated in several years and is fragmented to an extent that interferes with efficient delivery of care. For example, the system has separate modules for the operating room, the emergency department, outpatient clinics, and other patient care areas, making it difficult for clinicians to track the patient's entire journey within the health care system. Upgrading to the current Expanse system (or a similar product) must be a high priority to achieve the expected benefits of electronic health records, such as avoidance of unnecessary repeat testing, medication reconciliation across sites of care (which is particularly important for cancer care with chemotherapy), and integration of clinical decision support tools across all settings.
- Additional "workstations on wheels" and handheld devices are needed to minimize inefficiencies due to equipment sharing, bandwidth limitations, and resulting delayed entry of vital signs and other bedside observations into the electronic record.
- Nurses and others have noted delays or other difficulties purchasing certain expendable supplies, including paper, suture materials, intravenous infusion pumps, and lighting equipment. It appears that these difficulties have been overcome in most if not all cases, but at the expense of unnecessary staff effort and frustration.
- Modern electronic security systems are in place in the behavioral health units at both hospitals, [redacted]

My conclusion from these findings is that the patient care experience, as well as the staff experience, is being adversely affected by the current physical condition of the hospitals, and deferred upgrades of equipment or essential services in several key areas. These problems do not yet rise to the level of imminent quality and safety concerns, but they should be addressed as part of the conversion process or within a reasonable time period thereafter.

Part 3: Current Quality and Safety Performance

We used all-payer hospital discharge data from the Rhode Island Department of Health (RIDOH), which include the dates of admission and discharge for each inpatient episode from January 2016 through December 2022, to assess rates of all relevant Quality Indicators from the Agency for Healthcare Quality and Research (AHRQ), including Inpatient Quality Indicators (IQIs) and Patient Safety Indicators (PSIs). We also reviewed all publicly available quality measures from the Centers for Medicare & Medicaid Services (https://data.cms.gov/provider-data/search?theme=Hospitals), the Leapfrog Group, the Joint Commission, and Healthgrades. These quality measures cover multiple domains, including hospital outcomes (e.g., mortality rates for key conditions and procedures), patient safety (e.g., hospital-acquired complications), care coordination (e.g., readmission rates), patient experience (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] survey results), and healthcare associated infections. Our analyses were motivated by the need to evaluate the ability of the current local management at Roger Williams and OLF to ensure the quality and safety of care after the proposed conversion.

FINDINGS

On nearly all measures, Roger Williams and Fatima are performing near national or statewide averages, providing reasonable confidence that the current local management will be able to ensure the quality and safety of care after the proposed conversion. For example:

- 30-day risk-standardized mortality rates for patients with chronic obstructive pulmonary disease (COPD) were 8.7% at Roger Williams and 10.1% at OLF, versus 9.2% nationally.
- 30-day risk-standardized mortality rates for patients with heart failure were 11.9% at Roger Williams and 8.9% at OLF, versus 11.8% nationally.
- 30-day risk-standardized mortality rates for patients with pneumonia were 19.0% at Roger Williams and 19.8% at OLF, versus 18.2% nationally.
- AHRQ's all-payer composite of Mortality for Selected Inpatient Conditions (Inpatient Quality Indicator 91) was 22% better than the national average (ratio = 0.78; 95% confidence interval [CI], 0.60-0.96) at Roger Williams and 2% better than the national average (ratio = 0.98; 95% CI, 0.80-1.16) at OLF, based on combining 2021 and 2022 data.
- AHRQ's all-payer composite of Patient Safety and Adverse Events (Patient Safety Indicator 90) was very close to the national average at both Roger Williams (ratio = 0.95; 95% CI, 0.57-1.32) and OLF (ratio = 1.11; 95% CI, 0.80-1.41), based on combining 2021 and 2022 data. My evaluation of individual PSIs revealed no patterns of particular concern at these Prospect hospitals in 2021-2022.
- 30-day risk-standardized hospital-wide readmission rates were 14.1% at Roger Williams and 15.5% at OLF, versus 14.6% nationally.
- Standardized ratios for healthcare associated infections are well below the national average of 1, although these differences are unlikely to be statistically significant. Specifically, Roger Williams reported zero central line associated bloodstream infections (CLABSI), surgical site infections (SSI) after colon surgery, and methicillin resistant Staphylococcus aureus (MRSA) infections during the most recent reporting period, and the standardized ratios were 0.799 for

catheter associated urinary tract infections (CAUTI) and 0.185 for *Clostridioides difficele* infections, respectively. At OLF, no CLABSI, CAUTI, SSI after colon surgery, or *Clostridioides* infections were reported, but the ratio for MRSA infections was 1.970.

- The HCAHPS survey measures of patient experience at Prospect hospitals are generally very similar to, or lag modestly behind, national averages. For example, Roger Williams earned 3 stars (average) on nurse communication, doctor communication, discharge information, care transition, and recommending the hospital to others; 4 stars on cleanliness; and only 2 stars (below average) on staff responsiveness, communication about medicines, quietness, and overall hospital rating. OLF earned 3 stars (average) on all of these domains except 4 stars on staff responsiveness and discharge information.
- The Inpatient Psychiatric Facility measures indicate excessive use of physical restraints in the behavioral health unit at Roger Williams (1.43 hours per 1,000 hours of patient care, versus a national average of 0.32 hours), but not at OLF (0 hours per 1,000 hours of patient care). Hours spent in seclusion were below the national average at both facilities. Use of interventions for substance use disorders also lagged at Roger Williams: only 7% of eligible patients with alcohol abuse received or refused brief intervention during their inpatient stay (versus 56% at OLF and 61% nationally), only 19% of tobacco users received or refused medications to help quit tobacco (versus 78% at OLF and a national average of 71%).
- Hospital outpatient measures are generally very similar to national averages. For example, Roger Williams had similar or better-than-average rates of unplanned hospital visits after outpatient colonoscopy (12.0 versus 13.2 per 1,000 colonoscopies), inpatient admissions for patients receiving outpatient chemotherapy (9.6% versus 10.3%), and unplanned hospital visits after hospital outpatient surgery (ratio = 0.7, or 30% less than the national average).
- Emergency department (ED) measures are also similar to national averages, with similar percentages of patients who left without being seen (4% at Roger Williams and 3% at OL, versus a national average of 3%) and similar median time spent in the ED before leaving (207 minutes at Roger Williams and 194 minutes at OLF, versus 192 minutes statewide).
- Employee vaccination rates meet or exceed national benchmarks, particularly for COVID-19, with employee vaccination rates of 96.7% at Roger Williams and 95.8% at OLF, versus only 90.5% nationwide.
- Neither hospital voluntarily responds to the Leapfrog Group's Hospital Safety survey, which essentially constrains their current Hospital Safety Grades to C (on an A to F scale). On quantitative measures of harmful events, based on claims data submitted to CMS, both hospitals' performance was consistent with national averages.

My conclusion from these findings is that the Prospect hospitals have been able to maintain at least average levels of performance on most widely used quality measures, with the notable exceptions of a few patient-reported measures of patient experience at Roger Williams and a few process measures of inpatient psychiatric care at Roger Williams. These findings confirm effective quality and safety management by the current clinical leadership at Roger Williams and OLF, and suggest that the New CharterCARE System will be well positioned to maintain quality and safety after the proposed conversion, although attention to some areas of performance is still needed.

Part 4: Current Quality and Safety Processes

We reviewed all survey reports of the Prospect hospitals from the past five years, including statements of deficiencies (also known as CMS-2567 reports) and plans of correction (POC) developed by the hospitals and approved by RIDOH. These surveys were triggered by complaints, incidents, or allegations that were substantiated by the review team. This analysis provided context regarding quality and safety problems that the Prospect hospitals have encountered over the past five years, with particular focus on the past two years. Based on this historical understanding, as well as our review of the quality and safety measures summarized in Part 3, we conducted a detailed review of the "Quality and Patient Safety Assessment and Performance Improvement Plans" submitted by the hospitals, effective for calendar years 2023-2028. Our analyses were motivated by the need to evaluate the ability of the current local management at Roger Williams and OLF to ensure the quality and safety of care after the proposed conversion.

FINDINGS

Surveys of Roger Williams covered 11 POCs across multiple clinical domains, but none involved immediate jeopardy (IJ) to patients:

- Patient rights (grievances, physical restraints) – i.e., patient was put in soft wrist restraints without physician order (POC 12/2/21), patient was put in emergency restraint chair without physician order (POC 4/27/22).
- Medication errors – i.e., nurse did not administer intravenous lorazepam for patient with anxiety and chest pain (POC 1/19/20), patient with substance use disorder was discharged home without an opioid antagonist for emergency use, such as naloxone (POC 1/4/23).
- Pharmacy management – i.e., premixed anesthetic was not available in the pharmacy resulting in medication error in the operating room (POC 9/8/22).
- Radiology errors – i.e., radiology staff did not complete patient identification process resulting in performing X-ray on the wrong body part (POC 4/25/23).
- House staff supervision – i.e. no history and physician examination were documented over the weekend, resident administered 10 times the appropriate dose of digoxin (POC 10/9/20).

Surveys of OLF covered 21 POCs across multiple clinical domains, including 4 POCs that were classified as "immediate jeopardy" (IJ):

- Medication errors – i.e., delays in starting intravenous fluids, administration of wrong dose of insulin (IJ 3/17/23), failure to administer hydrocodone for pain management.
- Training of travel nursing staff – i.e., travel staff was not up to date on policies and procedures, delays in travel staff education (POC 8/13/21).
- Radiology errors – i.e., error in interpretation of mammography results resulting in unnecessary imaging of the patient, guidewire not recognized in CT (IJ POC 12/29/22), lack of communication of incorrect placement of central venous catheter on X-ray (IJ POC 7/26/21).
- Patient rights (physical restraints, privacy) – i.e., patient was put in physical restraints without physician order (POCs 4/6/22), patient personal privacy violation (POC 9/29/22).

- Patient Safety (abuse, falls, alarms not in order, patient safety events documentation) – i.e., patient was molested by another patient (IJ POC 7/12/19), inconsistent and delayed documentation of patient safety events (POC 3/17/23).
- Documentation (nursing documentation, ED staff) – i.e., lack of documentation of pressure injury in the transfer summary to another facility (POC 1/30/23).
- Infection control – i.e., COVID-19 requirements such as adequate cleaning of MRI equipment, staff not wearing personal protective equipment (POC 1/5/22, 10/28/20).

We found that the POCs addressed the immediate problems through staff education, policy revision, and auditing, but we also identified opportunities for long-term systems change and process improvement. In my experience, quality and safety problems are more likely to recur when the POC focuses on staff education but does not address underlying system problems and associated opportunities for improvement. For example, based on these events, we would also recommend that quality improvement teams:

- Perform failure mode effects analysis (FMEA) at Roger Williams focused on medication management including pharmacy dispensing, order verification, and stocking practices.
- Perform FMEA at Roger Williams focused on processes related to patient identification in the emergency department, operating room, and radiology suite.
- Work with medical staff office at Roger Williams to develop processes ensuring adequate house staff supervision, especially overnight and on weekends, and appropriate credentialing and recredentialing processes consistent with The Joint Commission requirements.
- Implement physician peer review processes for improving quality of care in radiology pertaining to interpretation and communication of results, in accord with The Joint Commission requirements and Conditions of Participation related to multidisciplinary Mortality and Morbidity committee activities. Of note, the same radiology group contracts with both Roger Williams and OLF.
- Work with nursing staff and leadership at OLF to improve understanding of patient rights and safety, including but not limited to medication safety and physical safety (falls, privacy), by conducting root cause analysis and utilizing plan-do-study-act (PDSA) cycles for quality improvement around medication administration errors.
- Formally evaluate the current patient safety reporting system at both facilities to ensure that it provides adequate and actionable management of patient safety events.
- Streamline and improve management of travel staff including minimizing use of travel staff, organizing systematic orientation activities, and ongoing training.
- Update and reinforce infection control policies including mechanisms for continuous review of policies, ongoing monitoring of staff compliance, and dissemination of policy updates.
- Perform FMEAs focused on the use of physical restraints and system changes to reduce use of physical restraints, given exceptionally high use at Roger Williams (e.g., 1.43 versus national benchmark of 0.32 in CMS data).

Upon detailed review of the Quality and Patient Safety Assessment and Performance Improvement Plans for Calendar Year 2023-2028, we noted several strengths and deficiencies. Strengths of these Plans include:

- Values of providing compassionate and empathic care, accepting responsibility for continuous performance improvement, collaborating to achieve common goals through teamwork, and preventing harm to patients.
- Strong emphasis on the culture of safety, including accepting the concept of Just Culture, implementing a non-punitive culture for reporting adverse events and unsafe situations, applying Safety Science and Lean methodologies, and viewing complications as systems and process issues to empower staff to improve patient safety.
- Appropriate inclusion of all key stakeholders, including engagement of patients and families, and attention to emerging concerns about health equity.

Limitations or deficiencies of these Quality and Patient Safety Assessment and Performance Improvement Plans for Calendar Year 2023-2028 include:

- The plans for the two hospitals are identical in almost every detail, even to the extent that the OLF Plan incorrectly references Roger Williams in several locations, and incorrectly cites excellence "in the area of cancer care" and "academic research efforts." As long as these hospitals are separately licensed and accredited, each hospital's performance improvement plan should be tailored to the specific circumstances, clinical activities, and recent history of that hospital.
- For example, Roger Williams' status as an Academic Comprehensive Cancer Program (accredited by the American College of Surgeons' Commission on Cancer, CoC) mandates (1) monitoring of the program's expected Estimated Performance Rates (EPR) for CoC-selected quality measures; (2) documentation of this monitoring activity, with performance rates equal to or greater than the corresponding EPR; and (3) implementation of action plans that review and address any elements of program performance below the expected EPR.[1]
- Similarly, Roger Williams' status as a Comprehensive Bariatric Surgery Center (accredited by the American College of Surgeon's Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) mandates (1) establishing a protocol for the notification of adverse events and the subsequent HIPAA-compliant peer review process; (2) at least one QI initiative per year, involving measurement, evaluation, and improvement of performance through implementation of a consistent quality improvement methodology; and (3) review of semi-annual risk adjusted reports with prioritization of any high outlier status.[2]
- The Plans do not identify a single individual with accountability and responsibility for improving quality and safety across the New CharterCARE System – a position typically labeled as "Chief Quality Officer," and typically filled by a nurse or physician with advanced training and

[1] https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/2020/
https://accreditation.facs.org/accreditationdocuments/CoC/Standards/Optimal_Resources_for_Cancer_Care_Feb_2023.pdf
URLs accessed June 9, 2024.

[2] https://www.facs.org/quality-programs/accreditation-and-verification/metabolic-and-bariatric-surgery-accreditation-and-quality-improvement-program/
https://www.facs.org/quality-programs/accreditation-and-verification/metabolic-and-bariatric-surgery-accreditation-and-quality-improvement-program/standards/
https://accreditation.facs.org/accreditationdocuments/MBSAQIP/web/Standard_7.2_%20August_2021.pdf
URLs accessed June 9, 2024.

substantial experience in quality and safety improvement, such as a Certified Professional in Healthcare Quality (CPHQ) or Certified Professional in Patient Safety (CPPS).[3] There is some risk in having the same Performance Improvement Committee function simultaneously as a "medical peer review committee," under Federal and state regulations, and as the body overseeing all "quality and safety activities of the hospital" (including incident reports, mortality reviews and malpractice claims).

- The Plans refer to comparative benchmarking relative to other organizations, including the University HealthSystem Consortium (UHC). However, UHC has not existed since 2015, when it merged with Novation and Voluntary Hospitals of America (VHA) to form Vizient.[4] The Plans do not explain which benchmarks, if any, derive from Vizient and its suite of data solutions.
- The Plans also refer to comparative benchmarking using Emergency Care Research Institute (ECRI) data. ECRI has not used that name since before 2007, when it became a designated Patient Safety Organization (PSO), and 2020, when it merged with the Institute for Safe Medication Practices. The Plans do not explain which benchmarks, if any, derive from ECRI, such as the National Medication Errors Reporting Program and the PSO program. The Appendix B list of Quality and Safety Indicators does not appear to include any indicators of medication errors or medication-related events, which is a special focus of ECRI's work.
- Some of the Quality and Safety Indicators listed in Appendix B either do not have standardized definitions or are no longer in widespread use. In general, hospitals should use measures that are aligned, insofar as possible, with requirements from The Joint Commission and CMS. For CY 2024 eCQM reporting, hospitals participating in the Hospital Inpatient Quality Reporting Program and the Promoting Interoperability Program are required to successfully submit four quarters of data for three electronic clinical quality measures (eCQMs) selected by CMS and three self-selected eCQMs. The eCQMs selected by CMS include one applicable to CharterCARE: Safe Use of Opioids—Concurrent Prescribing. The three self-selected eCQMs must come from this list of nine measures (none of which is mentioned in the existing plans):
    - HH-01 (CMS816v3) Hospital Harm—Severe Hypoglycemia
    - HH-02 (CMS871v3) Hospital Harm—Severe Hyperglycemia
    - HH-ORAE (CMS819v2) Hospital Harm—Opioid Related Adverse Events
    - GMCS (CMS986v2) Global Malnutrition Composite Score
    - VTE-1 (CMS108v12) Venous Thromboembolism Prophylaxis
    - VTE-2 (CMS190v12) Intensive Care Unit Venous Thromboembolism Prophylaxis
    - STK-02 (CMS104v12) Discharged on Antithrombotic Therapy
    - STK-03 (CMS71v13) Anticoagulation Therapy for Atrial Fibrillation/Flutter
    - STK-05 (CMS72v12) Antithrombotic Therapy By the End of Hospital Day 2

[3] https://nahq.org/individuals/cphq-certification/ and https://www.ihi.org/education/cpps . URLs accessed June 9, 2024.
[4] https://www.vizientinc.com/about-us ; URL accessed June 9, 2024.

Part 5: Recommendations Pursuant to RIGL Title 23, §23-17.14-8 to Ensure Safe and Adequate Treatment, and Appropriate Access

My recommendations fall into four categories of deferred maintenance, deficient quality improvement plans, deferred purchasing of equipment and services, and security risks. Recommendations within each category are listed below.

DEFERRED MAINTENANCE

Inspection of the facilities, interviews with key personnel, and review of selected documents have revealed significant evidence of deferred maintenance of the physical facilities. Conditions to address deferred maintenance may include:

- Prospect Medical Holdings (Prospect) shall take all necessary actions to ensure that the Centurion Foundation and the New CharterCARE System have the resources, plans, and approvals necessary to complete replacement of the roofs at both Roger Williams Medical Center and Our Lady of Fatima Hospital by a date to be determined.
- Prospect shall take all necessary actions to ensure that the Centurion Foundation and the New CharterCARE System have the resources, plans, and approvals necessary to complete replacement of the chilling tower at Roger Williams Medical Center and the condenser fan motor at Our Lady of Fatima (OLF) Hospital (Emergency Department) by a date to be determined.
- Prospect shall take all necessary actions to ensure that the Centurion Foundation and the New CharterCARE System have the resources, plans, and approvals necessary to replace the magnetic resonance imaging (MRI) equipment at OLF and the highest priority unresolved needs for imaging at Roger Williams Medical Center (e.g., computed tomography and/or nuclear medicine) by a date to be determined.

DEFICIENT QUALITY IMPROVEMENT PLANS

Interviews with key personnel and review of selected documents have revealed significant evidence of deficiencies in the quality improvement plans under which Centurion Foundation will operate the New CharterCARE System hospitals. Conditions to address deficiencies in these quality improvement plans may include:

- The New CharterCARE System shall identify a systemwide Chief Quality Officer (CQO), who should be a currently licensed health professional other than the Chief Nursing Officer, and who should be accountable for leading the Quality Councils and overseeing implementation of the system's Quality Improvement Plan and Patient Safety Plan.
- The New CharterCARE System shall adapt the "Quality and Patient Safety Assessment and Performance Improvement Plan Effective for Calendar Year 2023-2028" to meet the distinct needs of each hospital, insofar as each hospital is now licensed separately and operates services that are not available at the other hospital.

- The New CharterCARE System shall update comparative benchmarks appropriate for academically affiliated community hospitals (e.g., Vizient or equivalent quality dashboards tailored to the facilities' primary service lines and areas of prior deficiencies).
- The New CharterCARE System shall update Quality and Safety Indicators (Appendix B) for consistency with accreditation standards and the Centers for Medicare & Medicaid Services' Hospital Inpatient Quality Reporting (IQR) Program, Hospital Value-Based Purchasing Program, and Promoting Interoperability Program.
- The New CharterCARE System shall specify and implement efforts to address recently identified deficiencies, including but not limited to:
    - Use of physical restraints exceeding national benchmarks at Roger Williams.
    - Tobacco intervention, alcohol brief intervention, and other follow-up behavioral health care metrics that lag national benchmarks at Roger Williams.
    - HCAHPS (patient experience) scores that lag national benchmarks at Roger Williams, particularly with respect to nurses who "always helped" and "always explained medications," and "quiet at night."
    - Immediate Jeopardy findings at OLF related to "line of sight observation" in the emergency department, medication administration errors, and reporting and follow-up on critical findings from imaging.

DEFERRED PURCHASING OF EQUIPMENT AND SERVICES

Inspection of the facilities, interviews with key personnel, and review of selected documents have revealed significant evidence of deferred purchasing of equipment and services necessary for "safe and adequate treatment" of patients with serious illnesses and other special needs. Conditions to address deferred purchasing of equipment and services may include:

- Prospect shall initiate the process of upgrading the electronic health record (EHR) system at Roger Williams and OLF to Meditech Expanse or a product with similar capabilities, including the ability to support:
    - a cloud-based platform enabling connection with remote sites,
    - integration of key modules including operating room management, emergency department management, and pharmacy management,
    - recording of vital signs, point-of-care glucose values, and other critical information at the bedside using hand-held devices or mobile equipment with automated data transfer, and
    - improved adherence with barcoded medication administration to reduce medication-related errors.
- Prospect shall order new inpatient beds to replace beds that no longer provide optimal functionality to prevent pressure injuries, to reduce occupational health risks related to moving patients in bed and transferring patients out of bed, to reduce the risk of falls among high-risk patients, and to ensure that patients can contact nursing staff (and nurses can contact other staff) in a convenient, timely, and reliable manner.

SECURITY RISKS

[redacted] Conditions to address deferred security risks may include:

- Prospect shall develop and launch implementation of an updated security management plan, based on a complete risk assessment, pursuant to The Joint Commission standard (Environment of Care) EC.01.01.01 EP (Element of Performance) 5 and EC.02.01.01 EP 1 and EP 3. Specifically, the latter Elements of Performance require accredited facilities to:
    - Implement "its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts."
    - Take "action to minimize or eliminate identified safety and security risks in the physical environment."
- [redacted]
- Centurion Foundation and the New CharterCARE System shall implement this updated security management plan by a date to be determined, subject to verification by site inspection and interviews with hospital staff.

Appendix C

APPENDIX C

Quality and Patient Safety Assessment

and Performance Improvement Plan Requirements

I. Roger Williams' status as an Academic Comprehensive Cancer Program (accredited by the American College of Surgeons' Commission on Cancer, CoC) mandates:
   i. Monitoring of the program's expected Estimated Performance Rates (EPR) for CoC-selected quality measures;
   ii. Documentation of this monitoring activity, with performance rates equal to or greater than the corresponding EPR; and
   iii. Implementation of action plans that review and address any elements of program performance below the expected EPR.

II. Roger Williams' status as a Comprehensive Bariatric Surgery Center (accredited by the American College of Surgeon's Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) mandates:
   i. Establishing a protocol for the notification of adverse events and the subsequent HIPAA-compliant peer review process;
   ii. At least one QI initiative per year, involving measurement, evaluation, and improvement of performance through implementation of a consistent quality improvement methodology; and
   iii. Review of semi-annual risk adjusted reports with prioritization of any high outlier status.

III. The New CharterCARE System shall update comparative benchmarks appropriate for academically affiliated community hospitals (e.g., Vizient or equivalent dashboards).

IV. The New CharterCARE System shall update Quality and Safety Indicators (Appendix B) for consistency with accreditation standards and the Centers for Medicare & Medicaid Services' Hospital Inpatient Quality Reporting (IQR) Program, Hospital Value-Based Purchasing Program, and Promoting Interoperability Program. For CY 2024 eCQM reporting, hospitals participating in the Hospital IQR Program and the Promoting Interoperability Program are required to successfully submit four quarters of data for three electronic clinical quality measures (eCQMs) selected by CMS and three self-selected eCQMs. The eCQMs selected by CMS include one applicable to CharterCARE: Safe Use of Opioids—Concurrent Prescribing. The three self-selected eCQMs must come from this list of nine measures (none of which is mentioned in the existing plans):
   i. HH-01 (CMS816v3) Hospital Harm—Severe Hypoglycemia;
   ii. HH-02 (CMS871v3) Hospital Harm—Severe Hyperglycemia;
   iii. HH-ORAE (CMS819v2) Hospital Harm—Opioid Related Adverse Events;

iv. GMCS (CMS986v2) Global Malnutrition Composite Score;
v. VTE-1 (CMS108v12) Venous Thromboembolism Prophylaxis;
vi. VTE-2 (CMS190v12) Intensive Care Unit Venous Thromboembolism Prophylaxis;
vii. STK-02 (CMS104v12) Discharged on Antithrombotic Therapy;
viii. STK-03 (CMS71v13) Anticoagulation Therapy for Atrial Fibrillation/Flutter; and
ix. STK-05 (CMS72v12) Antithrombotic Therapy By the End of Hospital Day 2.

V. The New CharterCARE System shall specify and implement efforts to address recently identified deficiencies, including but not limited to:
i. Use of physical restraints exceeding national benchmarks at Roger Williams;
ii. Tobacco intervention, alcohol brief intervention, and other follow-up behavioral health care metrics that lag national benchmarks at Roger Williams;
iii. HCAHPS (patient experience) scores that lag national benchmarks at Roger Williams, particularly with respect to nurses who "always helped" and "always explained medications," and "quiet at night"; and
iv. Immediate Jeopardy findings related to "line of sight observation" in the emergency department, medication administration errors, and reporting and follow-up on critical findings from imaging.

Appendix D

APPENDIX D

Updated Security Plan Requirements

[redacted]

Appendix E

APPENDIX E

I. Weekly (Provide to RIDOH every Thursday):

a) Management reports of cash balance projections, such as a thirteen-week cash flow model, to illustrate forecasted weekly cash account balances for the next 13 weeks, actual cash account balances for the prior 13 weeks, and the categorization of cash inflows and outflows impacting the cash account balances.

II. Monthly (Provide to RIDOH 15 days after month end):

a) Management reports of financial and operational information, including but not limited to:

i. Statement of operations:

- Actual results, including common size income statement;
- Trending (Year-over-year, month-to-month, current year-to-date, prior year-to-date, etc.); and
- Comparison to budget with narrative describing any variance greater than 10% worse than budget;

ii. Balance sheet:

- Actual results; and
- Trending (Year-over-year, month-to-month, current year-to-date, prior year-to-date, etc.);

iii. Statement of Cash Flows:

- Actual results; and
- Year over year trends;

iv. Operating statistics (e.g., volume by department/site of service, key operational metrics, etc.):

- Actual results, by key service/department;
- Trending (Year-over-year, month-to-month, current year-to-date, prior year-to-date, etc.); and

- Comparison to budget;

b) Key financial metrics:

i. Liquidity:

- Current Ratio;
- Net Working Capital to % to Revenue;
- Amount of unused credit on each open line of credit;
- Days cash on hand;
- Days in accounts receivable;
- Days in accounts payable; and
- Accounts payable aging report;

ii. Profitability:

- Net income margin;
- Operating margin;
- EBITDA Margin; and
- Net to Gross Revenue, including trending;

v. Capitalization (include trending for each of the last 12 months):

- Debt service coverage;
- Capital expenditures;
- Change in Net Assets; and
- Debt to Net Assets ratio; and

vi. Any other financial covenants calculations which are required by the Bond Indenture, PACE loans, or other debt arrangements.

III. <u>Quarterly</u> (Provide to RIDOH 30 days after quarter end):

a) Operating forecasts;

b) Comparison of EBITDA Bridge forecast to actual results;

c) Incurred transition expenses to-date and estimate to complete; and

d) Charity care provided;

IV. <u>Annually</u> (Provide to RIDOH 90 days after year end):

a) Audited financial statements;

b) Management letters from independent auditor; and

c) 990 Tax Return;

V. <u>Other</u>:

a) Any compliance certificates and financial reports submitted to third parties, such as those required by the Bond Indenture, PACE loans, or other debt arrangements;

b) Any notification of defaults by third parties for any debt arrangements; and

c) Other financial reports as requested by RIDOH.

Appendix F

Department of Health

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Providence, RI 02908-5097

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APPENDIX F

CONDITIONS OF APPROVAL REPORTING CERTIFICATION:

The Centurion Foundation, Inc., CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, Inc., CharterCARE Our Lady of Fatima Hospital, Inc., Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC (collectively, the "Transacting Parties"

CERTIFICATION:

Please complete the following attestation form in accordance with the Condition being attested to.

For Conditions that pertain to Chamber, Inc. and its affiliates, please ensure that a separate attestation form is provided for each related Transacting Party. For Conditions that pertain to The Centurion Foundation, Inc. and its affiliates, please ensure that a separate attestation form is provided for each related Transacting Party.

Condition #_____

I hereby certify under penalty of perjury that the Transacting Parties met the requirements of the condition stated above and that all information provided for the period covering _____ *to* _____ *is complete, accurate, and true.*
mm-dd-yy mm-dd-yy

_____
Signed by the President or Chief Executive Officer

_____
Entity

Subscribed and sworn to before me on this_____ day of_____
20___.

_____
Notary Public
My Commission Expires: _____