Certificate of Need Application Form
Version 03.2011

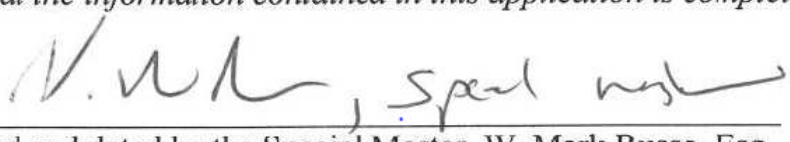
Name of Applicant	**The Westerly Hospital**
Title of Application	**15-Bed Inpatient Geriatric Psychiatry Program**
Date of Submission	**June 11, 2012** **Revised July 3, 2012** **Revised August 29, 2012**
Type of review	_____ Regular Review _____ Accelerated Review (provide letter from the state agency) __√__ Expeditious Review (complete Appendix A)
Tax Status of Applicant	__√__ Non-Profit _____ For-Profit

Pursuant to Chapter 15, Title 23 of The General Laws of Rhode Island, 1956, as amended, and Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15- CON).

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

Please have the appropriate individual attest to the following:

"I hereby certify that the information contained in this application is complete, accurate and true."



signed and dated by the Special Master, W. Mark Russo, Esq.

Table of Contents:

PROJECT DESCRIPTION AND CONTACT INFORMATION

1.) Please provide below an Executive Summary of the proposal.

The Westerly Hospital ("TWH") is a 125 bed short-term acute care hospital serving the population of Washington County, the South County Region of Rhode Island and New London County in Connecticut. The hospital is licensed for 125 beds and currently staffs for up to 70 beds. The proposed 15 inpatient geriatric psychiatric beds will be included within the existing hospital licensed capacity. TWH proposes to construct a single story 12,000 square foot extension to the existing hospital which will be used to house state-of-the-art behavioral health services including:

- **Fifteen (15) acute geropsychiatric beds in a seven (7) semi-private and one (1) private room configuration; all of the semi-private rooms contained herein are in compliance with the 2006 and 2010 edition of the Guidelines for Design and Construction of Health Care Facilities; and**

- **Hospital-based organized geriatric outpatient programs.**

A copy of the Superior Court Order granting the Special Master's Petition for Instructions Regarding a Certificate of Need Application to Establish a Geriatric Psychiatry Unit at The Westerly Hospital is attached at Tab 1 (the "Order"). As set forth in the Order, the Court held, among other things, that the Special Master was correct in seeking authority to pursue the proposed expansion of services and confirmed that the Special Master shall return to the Court for further authority prior to implementation of the 15 bed inpatient geriatric psychiatry program in the event this Certificate of Need Application is approved. The hospital fell into financial difficulties in early FYE2011 and filed for mastership protection in the Rhode Island Superior Court on December 7, 2011. For the fiscal year ended September 30, 2011 the hospital and its Affiliates ended with an Operating Loss of $5.206M. The filing was created primarily because of (i) a severe cash drain created by making loans to unprofitable affiliates and; (ii) a combination of diminishing revenues and substantially increased costs associated with servicing a defined benefit pension plan as well as costly employee benefit costs associated with its organized labor agreement. The hospital is in the process of working through a restructuring plan which has reduced expenses by several million dollars. In early 2012, the hospital was running losses of $1m/month. Presently, that loss rate is running at $250,000/month with an eye to achieving breakeven results by the last few months of the fiscal year. Copies of the unaudited FYE2011 financial statements and the FYE2012 statements through April 2012 are attached at Tab 2.

The hospital is currently in receipt of a purchase offer from Lawrence & Memorial Hospital ("L&M") and the parties have entered into a court-approved Asset Purchase Agreement. The Court held a sale hearing on August 28, 2012 at 9:30 a.m. to review and approve the offer and is scheduled to issue its decision on August 30, 2012. L&M proposes to purchase the hospital and related entities for total consideration of $69,138,653 ("the Purchase Price"). The Purchase Price includes $6.5 million of working capital into the hospital during the first two years after the closing. These funds 1) will be used to continue the economic turnaround plan, subject to review and final approval by L&M, that was initiated by the Special Master and aimed at returning The Westerly

Hospital to profitability and 2) include allocation of $1,850,000 to provide the equity for the proposed Geriatric-Psychiatric Program.

The nursing unit would contain a central nursing station to facilitate operational economies of scale. The organized outpatient program services will be provided in cooperation and coordination with the South Shore Center ("South Shore"), the community mental health center serving the South County Region and currently providing ED evaluations at the hospital. In addition, TWH will be working in a cooperative arrangement with South Shore's parent corporation, Gateway Healthcare, Inc., to provide a qualified Medical Director (Dr. Chabot's CV attached herewith at Tab 3), an on-site Associate Medical Director and both an inpatient and outpatient Nurse Navigator for clinical direction of the programs. TWH recognizes that a state-of-the-art behavioral health program includes the capacity to provide a complete range of therapeutic services e.g., medication management, therapeutic group and individual therapy and both inpatient and outpatient electroconvulsive therapy services ("ECT"). Initially, TWH plans to develop a referral relationship with hospitals currently providing ECT services as an initial alternative to developing the service internally. It is anticipated that once a demand for such services is established for the South County market, that TWH may enhance the proposed behavioral health services with the addition of an ECT service. The geriatric unit staff will be capable of addressing medical co-morbidities that are normally associated with these patient populations. This will include the ability to address the needs of patients requiring oxygen, indwelling catheters, and intravenous lines. Further, the unit will be capable of addressing the needs of patients having co-morbid chronic medical diseases requiring active treatment (e.g., high blood pressure, chronic obstructive pulmonary disease, congestive heart failure) along with their primary psychiatric diagnosis. In order to provide the necessary professional support staff, TWH is in the process of developing an Agreement with Gateway Healthcare, the parent corporation of South Shore, for the provision of: 1. a Medical Director, 2. a Chief Psychiatrist; 3. an inpatient Nurse Navigator and; 4. an outpatient Nurse Navigator. Both parties have agreed verbally to the general terms and drafting discussions are now taking place. There are no draft or executed agreements as of this date. The Gateway team as well as the TWH team will be available for any meetings required during the review process.

The projected capital expenditure associated with the proposed project is $5.9M. It is anticipated that the proposed project will become operational by October 2013.

A copy of the Diamond Healthcare Corporation feasibility study is attached at Tab 4.

2.)

Capital Cost	**$5,942,000**	From responses to Questions 10 and 11
Operating Cost	**$3,545,000**	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	**October / 2013**	Month and year

3.) Please provide the following information:

Information of the applicant:

Name:	**The Westerly Hospital**	Telephone #:	**401-596-6000**
Address:	**25 Wells Street, Westerly, RI**	Zip Code:	**02891**

Information of the facility (if different from applicant):

Name:		Telephone #:	
Address:		Zip Code:	

Information of the Special Master:

Name:	**W. Mark Russo, Special Master**	Telephone #:	**401-455-1000**
Address:	**55 Pine Street, 4th Fl., Providence, RI**	Zip Code:	**02903**
E-Mail:	**mrusso@frlawri.com**	Fax #:	**401-455-7778**

Information for the person to contact regarding this proposal:

Name:	**Patricia K. Rocha**	Telephone #:	**401-274-7200**
Address:	**Adler Pollock & Sheehan P.C., One Citizens Plaza, 8th Fl., Providence, RI**	Zip Code:	**02903**
E-Mail:	**procha@apslaw.com**	Fax #:	**401-351-4607**

4.) Select the category that best describes the facility named in Question 3.

[ ] Freestanding ambulatory surgical center [ ] Home Care Provider

[ ] Home Nursing Care Provider [√] Hospital

[ ] Hospice Provider

[ ] Inpatient rehabilitation center (including drug/alcohol treatment centers)

[ ] Multi-practice physician ambulatory surgery center

[ ] Multi-practice podiatry ambulatory surgery center

[ ] Nursing facility [ ] Other (specify): _____

5.) Please select each and every category that describes this proposal.

A. ___ construction, development or establishment of a new healthcare facility;
B. **X** a capital expenditure for:
   1. ___ health care equipment in excess of $2,250,000;
   2. **X** construction or renovation of a health care facility in excess of $5,250,000;
   3. ___ an acquisition by or on behalf of a health care facility or HMO by lease or donation;
   4. ___ acquisition of an existing health care facility, if the services or the bed capacity of the facility will be changed;
C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers);
D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, which ever is greater, and for which the related capital expenditures do not exceed $2,000,000
E. **X** the offering of a new health service with annualized costs in excess of $1,500,000;
F. ___ predevelopment activities not part of a proposal, but which cost in excess of $5,250,000;
G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility;
H. ___ tertiary or specialty care services: full body MRI, CT, cardiac catheterization, positron emission tomography, linear accelerators, open heart surgery, organ transplantation, and neonatal intensive care services. Or, expansion of an existing tertiary or specialty care service involving capital and/or operating expenses for additional equipment or facilities;

HEALTH PLANNING AND PUBLIC NEED

6.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency, including the Health Care Planning and Accountability Advisory Council, and any state plans for categorically defined programs. In your response, please identify all such priorities and how the proposal supports these priorities.

This proposal is consistent with the Department of Behavioral Healthcare, Developmental Disabilities and Hospital's ("BHDDH") Combined Substance Abuse and Mental Health Plan 2012-2013 submitted to the Substance Abuse and Mental Health Services Administration ("SAMHSA") that stated populations of particular concern include the elderly mentally ill: "This group has high levels of depression and other disorders as well as being at significantly greater risk from some types of psychotropic medications."[1] Since other studies[2] have found that utilization of mental health services among the geriatric population increases dependent on the proximity of those services to primary services, having inpatient and outpatient services provided on the Westerly campus should result in increased access to care. Other than the referenced BHDDH plan, the applicant has no other supporting documents from BHDDH. Accordingly, the proposed project helps to address the BHDDH concern related to the elderly with mental health issues.

7.) On a separate sheet of paper, please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:

A. Please identify the documented availability and accessibility problems, if any, of all existing facilities, equipments and services available in the state similar to the one proposed herein:

In Rhode Island ("RI"), there are 356 inpatient psychiatric beds located in seven (7) hospitals. In the Connecticut ("CT") portion of the defined market, there are two (2) hospitals with thirty-six (36) total psychiatric beds. The following Table summarizes the bed resources and the most recently reported annual utilization of these bed resources.

Name of Facility	Similar Services	Documented Availability Problems	Documented Accessibility Problems	Distance from Applicant (Miles)
Rhode Island Hospitals				
Butler Hospital	134 psychiatric beds	Y (Bed Board)	N	35
Kent Hospital Unit	20 psychiatric beds	N	N	27
Kent Hospital (Butler Unit)	20 Psychiatric beds	N	N	35
Landmark Medical Center	18 psychiatric beds	Y (Bed Board)	N	45
Newport Hospital	15 psychiatric beds	Y (Bed Board)	N	25
Our Lady of Fatima Hospital	76 psychiatric beds	N	N	35
Rhode Island Hospital	31 psychiatric beds	Y (Bed Board)	N	35
Roger Williams Medical Center	39 psychiatric beds	N	N	35
Connecticut Hospitals				
Lawrence and Memorial Hospital	18 psychiatric beds	Unknown	Unknown	18
W.W. Backus Hospital	18 psychiatric beds	Unknown	Unknown	19

[1] Combined Substance Abuse and Mental Health Plan 2012-2013, DBHDDH, September 1, 2011, page 56.
[2] Bartels, S.J., MD, Coakley, E.H., MPH, et al., Improving Access to Geriatric Mental Health Services: A Randomized Trial Comparing Treatment Engagement with Integrated Versus Enhanced Referral Care for Depression, Anxiety, and At-Rick Alcohol Use, American Journal of Psychiatry, 2004; 161:1455-1462

In addition to the 15 geriatric psychiatric inpatient beds, the project includes hospital-based intensive outpatient program ("IOP") services for the geriatric population. Using a prevalence-based projection methodology based on SAMHSA national data, it is estimated that IOP services will be the most appropriate level of psychiatric intervention for approximately 1,070 general adults and geriatrics in the defined market. IOP services are a complimentary service usually provided as part of a range of inpatient and outpatient psychiatric services. Providing IOP services as part of a continuum of inpatient and outpatient services allows for the opportunity of shared staffing and provision of economy of scale operations.

Age Group	Population	IOP Patients	CD-IOP Patients	Private Therapist
2012 Estimate				
18 to 64 Years	113,680	795	780	1,290
65 Years or Older	29,725	275	195	505
Totals	**143,405**	**1,070**	**975**	**1,795**
2017 Projection				
18 to 64 Years	114,105	835	785	1,390
65 Years or Older	34,615	315	230	590
Totals	**148,720**	**1,150**	**1,015**	**1,980**

Note: Private therapist includes psychiatrists, psychologists and mid-level clinicians.

It is estimated that IOP services will be the most appropriate level of behavioral health intervention for approximately 275 geriatric individuals in the defined market in 2012 increasing to 315 patients by 2017.

There are no hospital-based providers of geriatric intensive outpatient program services located within the defined market area. The closest hospital-based providers of organized outpatient (i.e., IOP or partial hospitalization program services) to the defined market are:[3]

- **Newport Hospital, Newport, RI – Child and adolescent and general adult individual and clinical psychiatric therapy services;**
- **Backus Hospital, Norwich, CT – General adult partial hospitalization ("PHP") and group therapy services; and**
- **Lawrence and Memorial Hospital, New London, CT – General adult IOP services.**

In addition, the following RI hospitals provide organized outpatient services:

- **Butler Hospital, Providence, RI – PHP for women, CD and eating disorders and general adult psychiatric, OP clinic;**
- **Our Lady of Fatima, North Providence, RI – General adult PHP services;**
- **Rhode Island Hospital, Providence, RI – General adult PHP and geriatric outpatient clinic services;**

[3] Note – The list of available outpatient services is based on the services listed on each hospital's individual website.

- **Roger Williams Medical Center, Providence, RI – General adult day treatment and PHP services;**
- **South County Hospital, Wakefield, RI – Outpatient clinic services.**

The South Shore Center (the community mental health program) provides child, adolescent and general adult outpatient therapy services in Charleston, Wakefield and North Kingstown. Likewise, the Providence Center and Gateway Healthcare provide behavioral healthcare services. None of the identified programs provide comparable hospital-based psychiatric outpatient program specifically oriented to needs of the geriatric population.

The lack of services oriented to the needs of the geriatric patient is further reflected in the data presented in the Zimmerman Report[4] which reported no geriatric outpatient psychiatric visits provided for the period 2005 through 2009 at either Kent Hospital or Newport Hospital.

7B.) Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in (A) above.

The following Table illustrates the utilization of the existing psychiatric beds in Rhode Island.

Year	Beds	ADC	Occupancy
2007	326	299.7	91.9%
2008	336	305.2	90.8%
2009	356	310.5	87.2%
3-Year Average	**339**	**305.1**	**90.0%**

Source: Zimmerman, Table 7.

As indicated by the Table, the existing inpatient psychiatric beds in Rhode Island are highly utilized. The high utilization of existing resources results in beds not being available when needed. The general unavailability of beds on demand is illustrated by an example from the Rhode Island statewide "bed board" report of available psychiatric beds. On April 30, 2012, it was reported that there were forty-three (43) patients waiting for placement in a psychiatric bed (27 adults and 16 minors). Six (6) of the forty-three (43) were in the South County Region[5].

Adding the proposed fifteen (15) geriatric beds to the inventory of available bed resources should result in greater accessibility – both in the South County Region and Rhode Island overall.

Mr. Zimmerman's methodology (performed in 2010) is significantly different than the methodology used by TWH to project and justify the need for the proposed project. The following discussion addresses the major characteristics and differences between Mr. Zimmerman's methodology and

[4] Zimmerman, Harvey, Assessment of Need for Increased Mental Health Inpatient Hospital Capacity in Rhode Island: 2010, Table 9A.

[5] Five (5) of the patients awaiting placement were at TWH. TWH does not maintain three years worth of bed board data and cannot provide an analysis as requested in the June 19, 2012 letter to Mr. Russo. TWH does not have the April 30, 2012 data today, as it is replaced daily. The example was given to illustrate the back up in hospital emergency rooms thereby evidencing statewide need.

TWH's methodology. As discussed below, use of the 2010 Zimmerman aggregate methodology is not applicable to determining the need for inpatient geriatric psychiatric beds.

Summary Comparison of Need Methodologies

A. <u>Zimmerman Demand-Only Methodology Adjusted for Compound Growth.</u>

The methodology used by Mr. Zimmerman[6] contains the following inherent assumptions:

- **All beds in RI are equally available and accessible to residents regardless of location (i.e., there are no availability or access issues that would impact utilization and a bed is available on demand).**
- **Utilization (i.e., discharges and patient days) is uniform throughout RI.**
- **Changes in population demographics (e.g., age distribution and growth) are directly reflected in the total discharges and patient days on a statewide basis.**
- **The trend in historical utilization alone is an accurate predictor of future utilization.**
- **All individuals in need of inpatient psychiatric services in the past received such services (i.e., everyone in need of inpatient or outpatient care received such care).**
- **There is no differentiation between the need for general adult and geriatric beds (i.e., bed need is aggregate).**

Based on these assumptions, Mr. Zimmerman's methodology determined the growth (or decline) in discharges and associated patient days for the period 2006 through 2009. A compound growth rate was determined for the aggregate of adult (18 to 64 years) patients and geriatric (65 years or older) patients. The following Exhibit summarizes the growth rates for discharges and patient days:

Age Group	Discharges	Patient Days
General Adult	4.58%	3.67%
Geriatric	(0.26%)	(1.24%)
Aggregate Total	3.95%	2.74%

The geriatric compounded growth rate using the Zimmerman methodology is a negative growth (i.e., a declining need). Application of the Zimmerman methodology to the two (2) specific age groups yields a different "picture" from the aggregate need presented in the Zimmerman Study.

Year	General Adult (+3.67%)		Geriatric (-1.24%)		Aggregate (+2.74%)	
	Days	Beds	Days	Beds	Days	Beds
2010	91,473	278	18,398	55	109,871	334
2011	94,830	289	18,170	55	113,000	344
2012	98,311	299	17,945	55	116,256	354
2013	101,919	310	17,722	54	119,641	364
2014	105,659	322	17,502	53	123,161	375

[6] Ibid.

Accounting for "rounding errors", the total beds needed in the aggregate, as set forth above, are very similar to the totals in the Zimmerman Study. However, application of the Zimmerman methodology to the two age groups (i.e., general adult and geriatric) results in an increasing need for general adult beds, but a decreasing need for geriatric beds, despite a growing geriatric population in RI. Therefore, use of the 2010 Zimmerman aggregate methodology is not applicable to determining the need for inpatient geriatric psychiatric beds.

<u>Westerly Use Rate per 1,000</u>. The data presented in the Zimmerman Study does provide sufficient information to prepare a population-based use rate analysis of need assuming that the use rate in the population is uniform throughout RI. A use rate based need projection utilizes the actual discharges and patient days consumed to determine a use rate per 1,000 population. This use rate is then applied to the estimated 2012 and projected 2017 populations of the defined market area[7] to provide an estimate of the demand generated by that population. The total patient days are then translated into bed need without the additional adjustment to account for availability contained in the Zimmerman methodology.

The need for adult and geriatric inpatient beds is based on the historical (2009) use rate for adult and geriatric discharges and related patient days in RI. The 2009 use rate is projected against the estimated 2012 and projected 2017 market populations to determine bed demand for adult and geriatric beds. Absent available data specific to CT, the RI use rate was applied to the CT portion of the primary market. The following Table summarizes the basic historical RI discharge and patient day use rates for adult and geriatric patients utilizing inpatient psychiatric services:[8]

Age Group	2009 Population	2009 Discharges	2009 Patient Days	2009 Discharges per 1,000	2009 Patient Days per 1,000
18 to 64 Years	674,435	11,909	88,235	17.66	130.83
65 Years or Older	149,676	1,632	18,629	10.90	124.46
Total Adult and Geriatric	824,111	13,541	106,864	16.43	129.67

Applying the historical use rate to the estimated 2012 and projected 2017 population of the defined market area is summarized as follows:

Age Group	2012 Population	2017 Population	2012 Days	2017 Days	2012 Bed Need	2017 Bed Need
18 to 64 Years	113,680	114,105	14,870	14,925	41	41
65 Years or Older	29,725	34,615	3,700	4,310	10	12
Total Adult and Geriatric	143,405	148,720	18,570	19,235	51	53

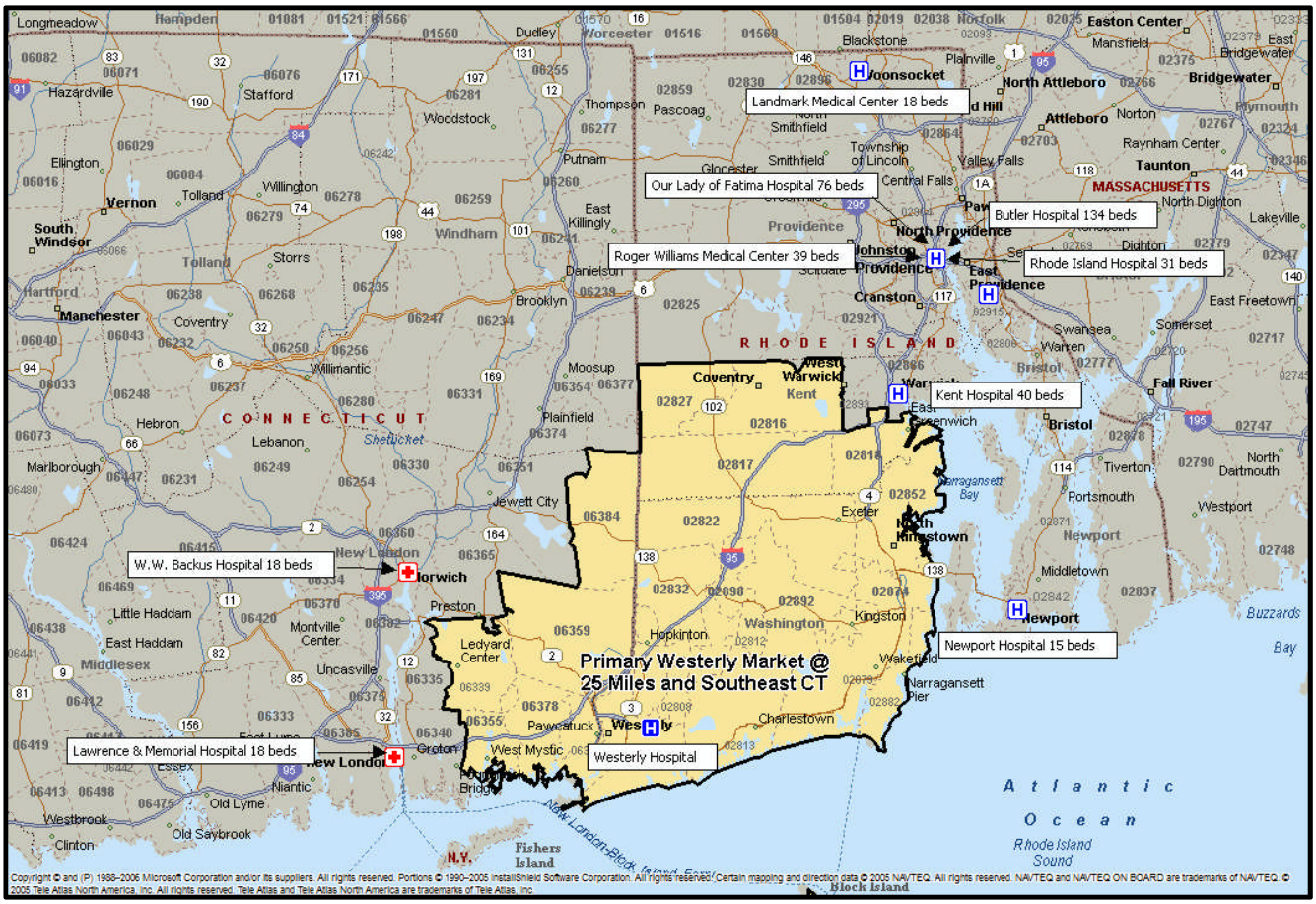
Applying the historical demand-based use rates for inpatient adult and geriatric psychiatric services to the estimated and projected primary market area populations, results in an estimated 2012 need for ten (10) geriatric beds, increasing to twelve (12) geriatric beds by 2017. The identified demand approximates the average daily census ("ADC") level projected for the defined market. In order to attain this ADC level, fifteen (15) actual beds must be available (i.e., separation by gender, medically complex patients). It should be noted that since the use rates from the Zimmerman Study result in a projected need for the defined market that exceeds the Zimmerman statewide estimate, it must be

[7] Population data is for the Neilson-Claritas data base, 2012 Population Estimates and 2017 Population Projections by zip code.
[8] Zimmerman, Tables 4A and 5A.

presumed that other areas of RI are in fact over-bedded since there are no psychiatric bed resources located in the defined market.

7C.) Please identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

The market for the proposed inpatient and outpatient psychiatric services at Westerly is displayed on the following map:[9]



The market includes all or portions of Washington County, Kent and Providence Counties in RI and New London County in CT. The market reflects the historical geographic areas from which Westerly has historically drawn medical-surgical patients.[10] The following Table lists the cities and towns comprising this primary market area.

[9] As discussed further herein, there is no "overlap" in the market between TWH's service area and existing resources. There is no hospital with inpatient psychiatric programs in TWH's service area.

[10] Table 3 of the Report prepared for the Rhode Island Department of Health Hospital Market Concentration and Market Share in Rhode Island, June 2009 indicates that in 2007 Westerly received 34% of its inpatient discharge volumes from Connecticut.

Zip Code	City/Town	County
02827	Greene	Kent
02816	Coventry	Kent
02818	East Greenwich	Kent
02852	North Kingstown	Washington
02822	Exeter	Washington
02898	Wyoming	Washington
02832	Hope Valley	Washington
02892	West Kingston	Washington
02812	Carolina	Washington
02874	Saunderstown	Washington
02894	Wood River Junction	Washington
02804	Ashaway	Washington
02808	Bradford	Washington
02813	Charlestown	Washington
02891	Westerly	Washington
02882	Narragansett	Washington
02807	Block Island	Washington
06384	Voluntown (CT)	New London
06359	North Stonington (CT)	New London
06339	Ledyard (CT)	New London
06378	Stonington (CT)	New London
06379	Pawcatuck (CT)	New London

The population for the primary market is estimated to be 181,640 persons in 2012, growing to a total population of 184,925 persons by 2017, a five year growth rate of 1.8%. The geriatric population of the primary market area is projected to grow 16.5% (4,890 persons) between 2012 and 2017. The following Table summarizes the estimated 2012 and projected 2017 populations for the primary market.

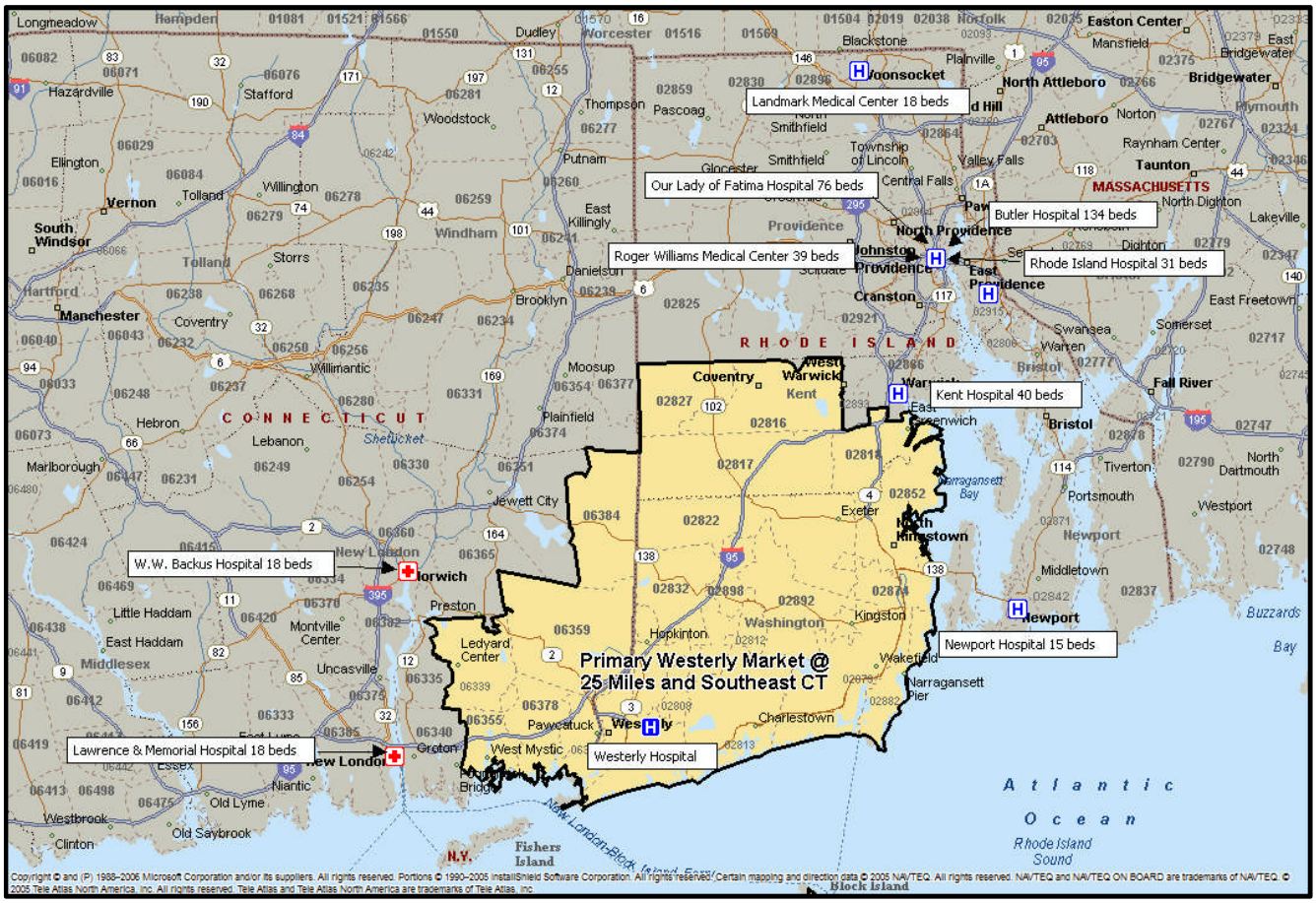
Age Group	2012 Population	Percent of Total	2017 Population	Percent of Total
Under 18	38,235	21.0%	36,205	18.6%
18 to 64 (Adult)	113,680	62.6%	114,105	63.6%
65 and Older (Geriatric)	29,725	16.4%	34,615	17.8%
Totals	**181,640**	**100.0%**	**184,925**	**100.0%**

Source: Neilson-Claritas Population Estimates and Projections, 2012 and 2017.

The Zimmerman Study indicates that 1) there is an existing "statewide need" for additional beds in RI, and 2) the existing beds are highly utilized. Therefore, there is no "overlap" in the market between the defined Westerly market and existing resources. The existing resources are by definition not routinely available due to their high utilization. Locating a fifteen (15) bed geriatric unit at Westerly Hospital would balance availability in RI by creating resources to serve a geographic area in which there are no inpatient psychiatric beds. There is no hospital with inpatient psychiatric programs in TWH's service area.

Patient origin data for similar existing programs is not available to the applicant. Butler Hospital, Our Lady of Fatima, Roger Williams Medical Center and Rhode Island Hospital are the only facilities with significant historical geriatric psychiatric volumes as reported on Table 4A of the Zimmerman Report. A general adult psychiatric program is not a comparable program to the

services proposed by TWH. As displayed on the following Exhibit, all of these facilities are located in the Providence area and removed from the defined market for TWH's project.



It is approximately twenty-five (25) miles from the center of the defined market to the facilities in Providence. Geriatric patients historically tend to seek specialty services (such as psychiatric services) at the same location where they obtain primary care services. Based on the distance from existing geriatric services, and the fact that TWH is the closest provider of primary care services for much of the defined market, it can be presumed that absent patient origin data to the contrary, that there is little market overlap with existing geriatric psychiatric programs.

The following Exhibit displays the estimated 2012 and projected 2017 populations for the RI and CT portions of the defined market.

Age Group	2012		2017		Total Market	
	RI	CT	RI	CT	2012	2017
Under 18	31,440	6,795	29,575	6,630	38,235	36,205
18 to 54 Years	71,115	14,375	67,945	13,795	85,490	81,740
55 to 64 Years	23,300	4,875	26,580	5,775	28,175	32,355
65 Years and Older	24,820	4,905	29,055	5,560	29,725	34,615
Total Population	**150,675**	**30,950**	**153,155**	**31,760**	**181,625**	**184,915**

The following Exhibit displays the estimated 2012 and projected 2017 bed need using the Use Rate-based methodology for both portions of the defined market.

Age Group	2012		2017		Total Market	
	RI	CT	RI	CT	2012	2017
General Adult	34	7	34	7	41	41
65 Years and Older	8	2	9	2	10	12
Total Beds	**42**	**9**	**43**	**9**	**51**	**53**

7D.) Please identify the health needs of the population in (C) relative to this proposal.

The method used to project the need for geriatric inpatient beds is based on the historical (2009) use rate for geriatric discharges and related patient days in Rhode Island. The 2009 use rate is projected against the estimated 2012 and projected 2017 market populations to determine bed demand for geriatric beds. The Rhode Island use rate was also applied to the Connecticut portion of the primary market.

<u>Historical Demand-Based Methodology.</u> The following Table summarizes the basic historical Rhode Island discharge and patient day use rates for adult and geriatric patients utilizing inpatient psychiatric services:[11]

Age Group	2009 Population	2009 Discharges	2009 Patient Days	2009 Discharges per 1,000	2009 Patient Days per 1,000
18 to 64 Years	674,435	11,909	88,235	17.66	130.83
65 Years or Older	149,676	1,632	18,629	10.90	124.46
Total Adult and Geriatric	**824,111**	**13,541**	**106,864**	**16.43**	**129.67**

Applying the historical use rate to the estimated 2012 and projected 2017 population of the primary market area is summarized as follows:

Age Group	2012 Population	2017 Population	2012 Days	2017 Days	2012 Bed Need	2017 Bed Need
18 to 64 Years	113,680	114,105	14,870	14,925	41	41
65 Years or Older	29,725	34,615	3,700	4,310	10	12
Total Adult and Geriatric	**143,405**	**148,720**	**18,570**	**19,235**	**51**	**53**

Applying the historical demand-based use rates for inpatient adult and geriatric psychiatric services to the estimated and projected primary market area populations results in an estimated 10 geriatric beds, increasing to twelve (12) geriatric beds by 2017.

It should be noted that while the demand for geriatric beds is between ten (10) and twelve (12) beds, two additional factors were considered when sizing the geriatric units at fifteen (15) beds. These factors are:

[11] Zimmerman, Tables 4A and 5A.

- **<u>Availability of beds on demand.</u> With a demand estimate of ten (10) beds in 2012 and twelve (12) beds by 2017, establishing a geriatric unit smaller than fifteen (15) beds would reduce the "availability on demand" for these beds. The 2012 demand would result in an occupancy rate of 67%. At a demand rate of twelve (12) beds, the occupancy rate would be 80%. The unit was sized to accommodate fluctuations in census above the demand-based ADC of 10 to 12 patients.**

- **<u>Psychiatric patients in Nursing Homes.</u> Studies have indicated that there is a large nursing home patient population that have a primary psychiatric diagnosis warranting intervention and treatment. It is estimated that there are approximately 500,000 persons with mental illness[12] residing in U.S. nursing homes on any given day.[13] One consequence of the downsizing of state psychiatric hospitals has been the use of nursing homes as a de facto mental health institution. In 2005, 27.4% of new nursing home admissions indicated schizophrenia, bipolar disorder, depression or anxiety. The estimated percentages for Rhode Island and Connecticut were 25.0% and 22.2% respectively.[14] Applying those percentages to the nursing home patient population in the defined market indicated that there are approximately 710 nursing home residents in the Rhode Island portion of the market and 200 nursing home residents in the Connecticut portion of the market with diagnosable mental illness requiring intervention. Given the high utilization of psychiatric beds in the State and the lack of available beds in the South County Region, it can be expected that these individuals represent an unexpressed need/demand for inpatient and related outpatient psychiatric services.**

Mr. Zimmerman's methodology is significantly different than the methodology used by Westerly to project and justify the need for the proposed project. The following Exhibit displays the major characteristics and differences between Mr. Zimmerman's methodology and the Westerly methodologies.

The methodology used by Mr. Zimmerman[15] apparently includes the following inherent assumptions:

- **All beds in RI are equally available and accessible to residents regardless of location (i.e., there are no availability or access issues that would impact utilization and a bed is available on demand).**
- **Utilization (i.e., discharges and patient days) is uniform throughout RI.**
- **Changes in population demographics (e.g., age distribution and growth) are directly reflected in the total discharges and patient days on a statewide basis.**
- **The trend in historical utilization alone is an accurate predictor of future utilization.**
- **All individuals in need of inpatient psychiatric services in the past received such services (i.e., everyone in need of inpatient or outpatient care received such care).**

[12] Excluding dementia.
[13] Fullerton, CA et al. <u>Trends in Mental Health Admissions to Nursing Homes 1999-2005</u>, Psychiatric Services.
[14] Grabowski, DC, Aschbrenner, KA, Feng, Z, and Mor, V. Mental Illness in Nursing Homes: Variations Acress States, Health Affairs, Volume 28:3, 689-700.
[15] Zimmerman, Harvey, Assessment of Need for Increased Mental Health Inpatient Hospital Capacity in Rhode Island: 2010.

- **There is no differentiation between the need for general adult and geriatric beds (i.e., bed need is aggregate).**

Based on these assumptions, Mr. Zimmerman's methodology determined the growth (or decline) in discharges and associated patient days for the period 2006 through 2009. A compound growth rate was determined for the aggregate of adult (18 to 64 years) patients and geriatric (65 years or older) patients. The following Exhibit summarizes the growth rates for discharges and patient days:

Age Group	Discharges	Patient Days
General Adult	4.58%	3.67%
Geriatric	(0.26%)	(1.24%)
Aggregate Total	3.95%	2.74%

The geriatric compounded annual growth rate using the Zimmerman methodology is a negative growth (i.e., a declining need). Application of the Zimmerman methodology to the two (2) specific age groups yields a different "picture" from the aggregate need presented in the Zimmerman Study.

Year	General Adult (+3.67%)		Geriatric (-1.24%)		Aggregate (+2.74%)	
	Days	Beds	Days	Beds	Days	Beds
2010	91,473	278	18,398	**55**	109,871	334
2011	94,830	289	18,170	**55**	113,000	344
2012	98,311	299	17,945	**55**	116,256	354
2013	101,919	310	17,722	**54**	119,641	364
2014	105,659	322	17,502	**53**	123,161	375

Accounting for "rounding errors", the total beds needed in the aggregate, as set forth above, are very similar to the totals in the Zimmerman Study. However, application of the Zimmerman methodology to the two age groups (i.e., general adult and geriatric) results in an increasing need for general adult beds, but a decreasing need for geriatric beds, despite a growing geriatric population in RI. Therefore, use of the 2010 Zimmerman aggregate methodology is not applicable to determine the need for inpatient geriatric psychiatric beds.

<u>Westerly Use Rate per 1,000</u>. The data presented in the Zimmerman Study does provide sufficient information to prepare a population-based use rate analysis of need assuming that the use rate in the population is uniform throughout RI. A use rate based need projection utilizes the actual discharges and patient days consumed to determine a use rate per 1,000 population. This use rate is then applied to the estimated 2012 and projected 2017 populations of the defined market area to provide an estimate of the demand generated by that population. The total patient days are then translated into bed need without the additional adjustment to account for availability contained in the Zimmerman methodology. This approach assumes that demand (i.e., use rates) is uniform throughout the State.

The need for adult and geriatric inpatient beds is based on the historical (2009) use rate for adult and geriatric discharges and related patient days in RI. The 2009 use rate is projected against the estimated 2012 and projected 2017 market populations to determine bed demand for adult and geriatric beds. Absent available data specific to CT, the RI use rate was applied to the CT portion of the primary market.

The following Table summarizes the basic historical RI discharge and patient day use rates for adult and geriatric patients utilizing inpatient psychiatric services:[16]

Age Group	2009 Population	2009 Discharges	2009 Patient Days	2009 Discharges per 1,000	2009 Patient Days per 1,000
18 to 64 Years	674,435	11,909	88,235	17.66	130.83
65 Years or Older	149,676	1,632	18,629	10.90	124.46
Total Adult and Geriatric	**824,111**	**13,541**	**106,864**	**16.43**	**129.67**

Applying the historical use rate to the estimated 2012 and projected 2017 population of the defined market area is summarized as follows:

Age Group	2012 Population	2017 Population	2012 Days	2017 Days	2012 Bed Need	2017 Bed Need
18 to 64 Years	**113,680**	**114,105**	**14,870**	**14,925**	**41**	**41**
65 Years or Older	**29,725**	**34,615**	**3,700**	**4,310**	**10**	**12**
Total Adult and Geriatric	**143,405**	**148,720**	**18,570**	**19,235**	**51**	**53**

Based on applying the historical demand-based use rates for inpatient adult and geriatric psychiatric services to the estimated and projected primary market area populations results in an estimated 2012 need for forty-one (41) adult and ten (10) geriatric beds, increasing to forty-one (41) adult and twelve (12) geriatric beds by 2017. It should be noted that since the use rates from the Zimmerman Study result in a projected need for the defined market that exceeds the Zimmerman statewide estimate, it must be presumed that other areas of RI are in fact over-bedded since there are no psychiatric bed resources located in the defined market.

<u>Adjusted Prevalence-Based Methodology.</u> In addition to the Use Rate approach, TWH has also examined the need in the defined market using a well-documented adjusted prevalence-based approach. This additional approach was not included in the original submission since RI had historically used a demand based approach. The prevalence-based methodology is included to provide an additional comparative to the Use Rate approach.

The adjusted prevalence-based methodology establishes need estimates based on the prevalence rate of individuals with an acute mental illness requiring intervention in order to allow the individual to perform normal activities of daily living. These rates are applied to the primary and regional market populations to provide an estimate of the baseline population at-risk of needing treatment services. In general, approximately 14.0% of the general adult population (persons 18 to 54 years of age), 14.7% of the older adult population (persons 55 to 64 years of age) and 19.8% of the geriatric population (persons 65 years or older) have an acute mental illness appropriate for intervention. Approximately 14.9% of the at-risk child and adolescent and 20% of the total at-risk adult and older adult (65 and older are not included in this adjustment) have an acute mental illness appropriate for inpatient intervention.[17] The following Exhibit summarizes the acute inpatient psychiatric bed need for the primary market.

[16] Zimmerman, Tables 4A and 5A.
[17] Ibid.

Based on national prevalence rates for inpatient psychiatric services, it is estimated that the defined market can be expected to generate approximately 4,335 adult, older adult and geriatric psychiatric admissions, equating to approximately sixty-seven (67) inpatient beds. The 2012 older adult and geriatric population in the primary market is estimated to generate 2,025 acute psychiatric admissions equating to an unadjusted need of forty-one (41) inpatient beds. It is projected that despite the projected decrease in the overall population between 2012 and 2017, the unadjusted need for older adult and geriatric beds will increase from forty-one (41) to forty-seven (47) beds as the population ages.

Age Group	2012 Population	2017 Population	Percent Inpatient Psychiatric Services	2012 Estimated Patient Days	2017 Projected Patient Days	2012 Estimated Bed Need	2017 Projected Bed Need
18 to 54	85,505	81,745	2.83%	9,680	9,260	26	25
55 to 64	28,175	32,360	2.97%	4,185	4,800	12	13
65 and Older	29,725	34,615	4.00%	10,710	12,460	29	34
Overall	**143,405**	**148,720**		**24,575**	**26,520**	**67**	**72**

Notes:

1. **At-Risk Patient Population is based on the calculation of the prevalence rate of acute mental illness in the population times the total age cohort population.**
2. **The estimated inpatients is the calculation of Percent At-Risk times Percentage appropriate for inpatient treatment. Inpatient rates based on cited Surgeon General's Report, NIMH.**
3. **Based on lengths of stay of 4 days for 18 to 54, 5 days for and 55 to 64 and 9 days for 65 and older.**

Source:

U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999, pages 46 through 48.

The prevalence-based bed need assumes no barriers to access and includes patients receiving treatment in alternative settings. The primary "adjustments" to the prevalence–based methodology that account for patients receiving treatment in alternative setting or not able to access services are:

- **Individuals in nursing homes with a severe mental illness ("SMI"). In RI, the estimated percentage of nursing home patients with SMI was 25.0%. In CT, the estimated percentage of nursing home patients with SMI was 22.2%. Since the majority of patients in nursing homes are 55 years and older, this adjustment is applied only to the older adult and geriatric populations. The adjustment equates to a reduction in the older adult and geriatric beds of fourteen (14) older adult and geriatric beds.[18]**
- **Individuals in alternative custodial settings. It is estimated that approximately 15% of individuals incarcerated in custodial settings have a severe mental illness that would otherwise warrant inpatient treatment. This adjustment is generally limited to a general adult population. The adjustment equates to a reduction in the general adult beds of four (4) beds in both 2012 and 2017.**

[18] Grabowski, DC, Aschbrenner, KA, Feng, Z, and Mor, V. Mental Illness in Nursing Homes: Variations Across States, Health Affairs, Volume 28:3, 689-700.

The unmet need for inpatient general adult and older adult/geriatric beds, as adjusted is summarized in the following Exhibit.

Methodology	2012 Estimated					2017 Projected				
	Adult	Older Adult	Total General Adult	Geriatric	Total Beds	Adult	Older Adult	Total General Adult	Geriatric	Total Beds
Demand-Based										
Calculated Need	31	10	41	10	51	28	13	41	12	53
Adjustments	0	0	0	0	0	0	0	0	0	0
Net Need	***31***	***10***	***41***	***10***	***51***	***28***	***13***	***41***	***12***	***53***
Prevalence-Based										
Calculated Need	26	12	38	29	67	25	13	38	34	72
Adjustments	(4)	0	(4)	(17)	(21)	(4)	0	(4)	(18)	(22)
Net Need	***22***	***12***	***34***	***12***	***46***	***21***	***13***	***34***	***16***	***50***

In summary, both the demand-based Use Rate and the Adjusted Prevalence-Based need methodologies yield similar need estimates for the defined market area. It should be further noted that Table 6 of the Zimmerman Study indicates that the existing psychiatric inpatient resources in RI are highly utilized (87.2% including the additional twenty [20] beds at Butler Hospital). Further, Mr. Zimmerman's methodology reflects an additional availability adjustment to reflect the high utilization of existing beds.

TWH would like to emphasize that it is not requesting general adult psychiatric beds. The application is specifically for geriatric psychiatric beds. Further, Butler Hospital, Our Lady of Fatima, Roger Williams Medical Center and Rhode Island Hospital are the only facilities with significant historical geriatric psychiatric volumes as reported on Table 4A of the Zimmerman Report. All of these facilities are located in the immediate Providence market. Many of these facilities are tertiary facilities with large "service areas" which in the instance of Butler Hospital could be considered to be the entire State of RI. However, as of FY or CY 2009, the psychiatric occupancy rate for these facilities was:

- **Butler Hospital: 94.03%;**
- **Rhode Island Hospital: 105.20%;**
- **Our Lady of Fatima: 79.14%;**
- **Roger Williams Medical Center: 84.24%.**

In effect, these are highly utilized psychiatric programs. Unit specific utilization data (i.e., general adult versus geriatric) was not publicly available. TWH maintains that highly utilized facilities which are located in the Providence market are not routinely available or accessible to the population of the defined Westerly market.

Likewise, non-geriatric psychiatric beds are not a reasonable alternative site of care for geriatric patients who have differing treatment needs from younger more acutely intensive general adult patients. As a result, any overlap with service areas of other hospitals' general adult psychiatric units cannot meet the needs of the geriatric psychiatric population.

Outpatient Services. A combined prevalence rate and use rate approach was used to estimate the potential need in the market for organized geriatric outpatient program services. The need for organized hospital-based geriatric outpatient program services is based on the Substance Abuse and Mental Health Services Administration's Office of Applied Statistics' analysis of mental health services in the United States.[19]

It is estimated that IOP services will be the most appropriate level of psychiatric intervention for approximately 1,070 general adults and geriatrics in the defined market. IOP services are a complimentary service usually provided as part of a range of inpatient and outpatient psychiatric services. Providing IOP services as part of a continuum of inpatient and outpatient services allows for the opportunity of shared staffing and provision of economy of scale operations.

Age Group	Population	IOP Patients	CD-IOP Patients	Private Therapist
2012 Estimate				
18 to 64 Years	113,680	795	780	1,290
65 Years or Older	29,725	275	195	505
Totals	**143,405**	**1,070**	**975**	**1,795**
2017 Projection				
18 to 64 Years	114,105	835	785	1,390
65 Years or Older	34,615	315	230	590
Totals	**148,720**	**1,150**	**1,015**	**1,980**

Note: Private therapist includes psychiatrists, psychologists and mid-level clinicians.

It is estimated that IOP services will be the most appropriate level of behavioral health intervention for approximately 275 geriatric individuals in the defined market in 2012 increasing to 315 patients by 2017.

There are no hospital-based providers of geriatric intensive outpatient program services located within the defined market area. The closest hospital-based providers of organized outpatient (i.e., IOP or partial hospitalization program services) to the defined market are:[20]

- **Newport Hospital, Newport, RI – Child and adolescent and general adult individual and clinical psychiatric therapy services;**
- **Backus Hospital, Norwich, CT – General adult partial hospitalization ("PHP") and group therapy services; and**
- **Lawrence and Memorial Hospital, New London, CT – General adult IOP services.**

In addition, the following RI hospitals provide organized outpatient services:

- **Butler Hospital, Providence, RI – PHP for women, CD and eating disorders and general adult psychiatric, OP clinic;**
- **Our Lady of Fatima, North Providence, RI – General adult PHP services;**

[19] SAMHSA Office of Applied Statistics, Patterns of Mental Health Services Utilization and Substance Abuse Use Among Adults, 2000 and 2001. Chapter 4: Characteristics of Persons Receiving Outpatient Treatment, 2004.
[20] Note – The list of available outpatient services is based on the services listed on each hospital's individual website.

- **Rhode Island Hospital, Providence, RI – General adult PHP and geriatric outpatient clinic Our services;**
- **Roger Williams Medical Center, Providence, RI – General adult day treatment and PHP services;**
- **South County Hospital, Wakefield, RI – Outpatient clinic services.**

The South Shore Center (the community mental health program) provides child, adolescent and general adult outpatient therapy services in Charleston, Wakefield and North Kingstown. None of the identified programs provide comparable hospital-based psychiatric outpatient program specifically oriented to needs of the geriatric population.

7E.) Please identify utilization data for the past three years (if existing service) and as projected through the next three years, after implementation, for each separate area of service affected by this proposal. Please identify the units of service used.

Actual (last 3 years) N/A	**FY 1**	**FY 2**	**FY 3**
Hours of Operation			
Utilization (#)			
Throughput Possible (#)			
Utilization Rate (%)			

Projected Inpatient	**FY 2013**	**FY 2014**	**FY 2015**
Hours of Operation	**24/7**	**24/7**	**24/7**
Utilization Patient Days	**3,285**	**4,015**	**4,380**
Throughput Possible days	**5,475**	**5,475**	**5,475**
Utilization Rate (%)	**60%**	**73%**	**80%**

Projected Outpatient	**FY 2013**	**FY 2014**	**FY 2015**
Hours of Operation	**9-5**	**9-5**	**9-5**
Utilization Hours	**5,500**	**6,188**	**6,325**
Throughput Possible Hours	**7,500**	**7,500**	**7,500**
Utilization Rate (%)	**73.3%**	**82.5%**	**84.3%**

7F.) Please identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

Based on the demand-based methodology, the unmet need for inpatient psychiatric beds in the defined market is:

Age Group	2012 Population	2017 Population	2012 Days	2017 Days	2012 Bed Need	2017 Bed Need
18 to 64 Years	113,680	114,105	14,870	14,925	41	41
65 Years or Older	29,725	34,615	3,700	4,310	10	12
Total Adult and Geriatric	**143,405**	**148,720**	**18,570**	**19,235**	**51**	**53**

The proposed project will address all of the demand-based unmet need for geriatric psychiatric beds. Further, by having secure inpatient units capable that accept both voluntary and involuntary admissions, and which are capable of addressing the treatment needs of patients with co-morbid psychiatric and medical conditions, the proposed inpatient program meets a significant community need. By complimenting the proposed inpatient beds with organized hospital-based outpatient geriatric services, TWH can assist the South Shore Center to address the needs of the geriatric psychiatric population while adding geriatric outpatient services to the array of available services in the south county region.

As described in TWH's response to Question 7B, it is the difference between Mr. Zimmerman's compound growth approach of utilization and TWH's application of the actual use rate in the population to the population of the defined Westerly psychiatric market for geriatric psychiatric services. The use rate approach is further confirmed through use of an adjusted prevalence-based methodology.

This application identifies a specific market/service area for the services to be provided. Mr. Zimmerman's study inherently assumes all beds are equally available and accessible regardless of location to all populations within the State of RI. TWH's analysis indicates that the population of the defined market (a) is underserved in terms of resource availability with no beds located within the defined market; and (b) there is a sufficient population based on both a demand-based use rate analysis and an adjusted prevalence-based analysis.

TWH would like to emphasize that it is not requesting general adult psychiatric beds. The application is specifically for geriatric psychiatric beds. Non-geriatric psychiatric beds are not a reasonable alternative site of care for geriatric patients who have differing treatment needs from younger more acutely intensive general adult patients. As a result, any overlap with service areas of other hospitals' general adult psychiatric units is not relevant to this discussion. Moreover, there are no hospitals with inpatient psychiatric programs in TWH's service area.

Butler Hospital, Our Lady of Fatima, Roger Williams Medical Center and Rhode Island Hospital are the only facilities with significant historical geriatric psychiatric volumes as reported on Table 4A of the Zimmerman Report. All of these facilities are located in the immediate Providence market. Many of these facilities are tertiary facilities with large "service areas" which in the

instance of Butler Hospital could be considered to be the entire State of RI. However, as of FY or CY 2009, the psychiatric occupancy rate for these facilities was:

- **Butler Hospital: 94.03%;**
- **Rhode Island Hospital: 105.20%;**
- **Our Lady of Fatima: 79.14%;**
- **Roger Williams Medical Center: 84.24%.**

In effect, these are highly utilized psychiatric programs. Unit specific utilization data (i.e., general adult versus geriatric) was not publicly available. Westerly maintains that highly utilized facilities which are clustered in the Providence market are not routinely available or accessible to the population of the defined Westerly market.

7G.) Please identify and evaluate alternative proposals to satisfy the unmet need identified in (F) above, including developing a collaborative approach with existing providers of similar services.

In developing our proposal to build the stand alone 15-bed In and Outpatient Geriatric Psych Facility, TWH has worked collaboratively on this proposal with the other ambulatory mental health services in the community (there are no other inpatient psychiatric services offered within our service area). In our early feasibility work, performed by Diamond Healthcare Corporation, a national behavioral health consulting and management services organization , all sections of the community that provide portals of access to the State's mental health services (Psychiatrists, Ambulatory Centers, Nursing Homes, Chamber of Commerce, Police Department, etc) were interviewed concerning the need for these services. All of these indicated a need for a comprehensive Geri-Psych hospital-based program. If the outreach is extended to the more distant providers of this service in the State, they are extremely busy and have no capacity to undertake a collaborative effort.

TWH is working collaboratively with Gateway Health and the South Shore Center in developing the program. As set forth above, there are no existing inpatient geriatric psychiatric programs in TWH's service area with which to collaborate. Moreover, due to the distance and high utilization of existing programs outside TWH's service area, other collaborative approaches are not available or accessible to TWH's patient population. Due diligence, including the Diamond Healthcare Corporation feasibility study, confirmed the lack of collaboration possibilities with existing inpatient providers outside TWH's service area.

TWH evaluated three basic alternative proposals for meeting the physical space needs:

1. **Renovate space within the main hospital: This proved impossible for two reasons; 1.) There was no continuous space large enough to meet the needs of the unit within the main hospital building and; 2.) If there were space, early estimates of both the costs (and the unforeseeable costs) of renovating within the main building were know to be prohibitive (from looking at other projects).**

2. **Using available land, build a separate stand-alone facility to house the program. This would essentially be a separate small hospital sharing the Campus. Again, initial cost estimates for this type of approach were prohibitive**
3. **Create an attached or nearby related building that would contain only the clinical space needed for the Program. This building would not have the infrastructure of a stand-alone hospital (dietary, laundry, support services, etc) and would serve as a clinical extension of the main hospital. The initial plan was to attach this unit to the building, but topographical considerations make it less expensive to connect the building to the current hospital via a short, covered walkway.**

   Alternative 3 was ultimately selected as providing the most benefit for the least cost.

7H.) Please provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (G) above.

The proposed project is the preferred alternative since it addresses the unmet needs of the geriatric population, is consistent with the overall state need (and methodology) identified in the Zimmerman Assessment of Need for Increased Mental Health Inpatient Hospital Capacity in Rhode Island, 2010, provides for treating both voluntary and involuntary admissions and provides a complimentary range of organized outpatient services that enhance the geriatric services available through the South Shore Center and provide for a geriatric continuum of care.

Given that Westerly believes that there is a significant unrealized demand for geriatric psychiatric services among the residents in the defined market's nursing homes, it was decided that the beds should be oriented to the needs of the geriatric population. Westerly believes that the proposed project which addresses the geriatric needs in the market is the preferable model.

As set forth in response to 7G, in developing our proposal to build the stand alone 15-bed In and Outpatient Geriatric Psych Facility, TWH has worked collaboratively on this proposal with the other ambulatory mental health services in the community (there are no other inpatient psychiatric services offered within our service area). In our early feasibility work, performed by Diamond Healthcare Corporation, a national behavioral health consulting and management services organization, all sections of the community that provide portals of access to the State's mental health services (Psychiatrists, Ambulatory Centers, Nursing Homes, Chamber of Commerce, Police Department, etc.) were interviewed concerning the need for these services. All of these indicated a need for a comprehensive Geri-Psych hospital-based program. If the outreach is extended to the more distant providers of this service in the State, they are extremely busy and have no capacity to undertake a collaborative effort.

TWH is working collaboratively with Gateway Health and the South Shore Center in developing the program. As set forth above, there are no existing inpatient geriatric psychiatric programs in TWH's service area with which to collaborate. Moreover, due to the distance and high utilization of existing programs outside TWH's service area, other collaborative approaches are not available or accessible to TWH's patient population. Due diligence, including the Diamond Healthcare

Corporation feasibility study, confirmed the lack of collaboration with existing inpatient providers outside TWH's service area.

Likewise, as set forth in response to 7G, TWH evaluated three basic alternative proposals for meeting the physical space needs:

1. **Renovate space within the main hospital: This proved impossible for two reasons; 1. There was no continuous space large enough to meet the needs of the unit within the main hospital building and; 2. If there were space, early estimates of both the costs (and the unforeseeable costs) of renovating within the main building were know to be prohibitive (from looking at other projects).**
2. **Using available land, build a separate stand-alone facility to house the program. This would essentially be a separate small hospital sharing the Campus. Again, initial cost estimates for this type of approach were prohibitive**
3. **Create an attached or nearby related building that would contain only the clinical space needed for the Program. This building would not have the infrastructure of a stand-alone hospital (dietary, laundry, support services, etc) and would serve as a clinical extension of the main hospital. The initial plan was to attach this unit to the building, but topographical considerations make it less expensive to connect the building to the current hospital via a short, covered walkway.**

   Alternative 3 was ultimately selected as providing the most benefit for the least cost.

HEALTH DISPARITIES AND CHARITY CARE

8.) The RI Department of Health defines health disparities as inequalities in health status, disease incidence, disease prevalence, morbidity, or mortality rates between populations as impacted by access to services, quality of services, and environmental triggers. Disparately affected populations may be described by race & ethnicity, age, disability status, level of education, gender, geographic location, income, or sexual orientation.

   A. Please describe all health disparities in the applicant's service area. Provide all appropriate documentation to substantiate your response including any assessments and data that describe the health disparities.

Based on recent State Demographic data, TWH's service area contains fewer patients that would tend to suffer disparities in the access to care:

Factor	TWH Market %	Statewide %
Black Persons	1.0%	6.7%
Hispanic or Latin Origin	3.2%	12.4%
American Indian	.5%	.6%
High School Grads	85.1%	83.7%
Bach. Degree or Higher	27.8%	30.3%
Per Capita Income	$29,697	$26,707
Persons below Poverty Level	7.7%	12.2%

See Tab 5, including 2011 Rural Health Report (including, but not limited to Westerly service area), Rhode Island Language Data (including Westerly data on non-english speakers) and RI Racial/Ethnic Population Data by Health Care Service Region (including Westerly Health Care Service Region for the purpose of emergency preparedness).

TWH's market does contain a substantially greater percentage of persons over 65, than the State average. Based upon 2010 data, the difference is 18.5% vs. 14.4%. The general adult and geriatric populations experience significantly difference annual prevalence rates of an acute mental illness requiring intervention in order to allow the individual to perform normal activities of daily living. The differing annual prevalence rate are based on studies performed for the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH) and in the Surgeon General of the United States Report on Mental Health published in 1999.[21] In general, approximately 14.0% of the general adult population (persons 18 to 54 years of age), 14.7% of the older adult population (persons 55 to 64 years of age) and 19.8% of the geriatric population (persons 65 years or older) have an acute mental illness appropriate for intervention.

In addition to the disparate prevalence rates, there is a disparity in service availability between the services available to the child, adolescent and adult populations and those available to the geriatric population. The closest inpatient psychiatric services currently available to the defined market population are the general adult programs located at Kent Hospital and Newport Hospital. Over the period of 2007 through 2009, Kent Hospital averaged an ADC of 0.9 geriatric patients with Newport Hospital also averaging an ADC of 0.9 geriatric patients. Applying the 19.8% geriatric prevalence rate to the geriatric population of defined market results in an estimate of 5,885 geriatric individuals having an acute psychiatric issue warranting intervention. The Same NIMH Study indicated that approximately 20.2% of the geriatric patients with an acute psychiatric issue required an inpatient level of intervention. Applying the use rate to the defined market at-risk geriatric population (i.e., 5,885 persons) results in a 2012 estimate of 1,185 geriatric individuals requiring inpatient psychiatric treatment. Applying RI's geriatric psychiatric average length of stay of 11.42 days to the estimated geriatric inpatient population (i.e., 1,185) in a total estimate of 13,530 days of care needed, which equates to an average daily census of 37.0 patients/beds. The disparity between an estimated need of 37 beds versus the historical expressed demand (1.8 ADC) represented by the most available resources would indicate that there is a significant access issue for the geriatric population in the south county region.

[21] U. S . Department of Health and Human Services, Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999, pages 46 through 48.

B. Discuss the impact of the proposal on reducing and/or eliminating health disparities in the applicant's service area.

The proposed project will directly address the described disparity in the geriatric population in service availability by establishing a continuum of inpatient and related organized hospital-based psychiatric services for the geriatric patient. The proposed project also would augment the availability of geriatric outpatient services.

9.) Please provide a copy of the applicant's charity care policies and procedures and charity care application form.

See <u>Tab 6</u> – including charity care application form.

FINANCIAL ANALYSIS

10.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., $112,527 = $113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	**Percent of Total**
Survey/Studies	$ 0	%
Fees/Permits	$ 0	%
Architect	$ 510	9%
"Soft" Construction Costs	$ 510	9%
Site Preparation	$ 450	8%
Demolition	$ 0	%
Renovation	$ 0	%
New Construction	$ 3,380	57%
Contingency	$ 380	6%
"Hard" Construction Costs	$ 4,210	71%
Furnishings	$5 4	1%
Movable Equipment	$ 228	4%
Fixed Equipment	$ 114	2%
"Equipment" Costs	$396	7%
Capitalized Interest	$246	4%
Bond Costs/Insurance	$	%
Debt Services Reserve[1]	$450	8%
Accounting/Legal	$10	0%
Financing Fees	$120	2%
"Financing" Costs	$826	14%
Land	$ 0	%
Other (specify _____)	$ 0	%
"Other" Costs	$	%
TOTAL CAPITAL COSTS	**$5,942**	**100%**

[1] Should not exceed the first full year's annual debt payment.

B.) Please provide a detailed description of how the contingency cost in (A) above was determined.

A 10% contingency at the time of schematic design is normal for the industry. The contingency is for unknown situations that might affect the cost of the construction, including, without limitation, sub-straight bearing capacity, presence of ledge or rock formations in the excavation area, site conditions that may exist that will make extension of utilities in the main hospital difficult, relocation of existing storm and sanitary lines depending upon actual structural design of the foundation, presence of rock/ledge in the newly created parking lot area, mechanical design considerations to meet energy star requirements and actual construction market conditions at the time of implementation.

C.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

i. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.

Plan for acquiring funds; The capital costs of this program which run to some $5.942M will be funded by hospital equity of $1,850,000 and a bond issue of $4.092M, which equals $4,092,800 of construction funds. After the first few months, the cash flows of the Unit will carry the annual Debt Service of $392,632. In the early months, this will be funded by hospital cash flows. Operations will be self-sustaining shortly after start-up.

As set forth in response to question 1, TWH is currently in mastership proceedings. The hospital is currently in receipt of a purchase offer from Lawrence & Memorial Hospital ("L&M") and the parties have entered into a court-approved Asset Purchase Agreement. The Court held a sale hearing on August 28, 2012 at 9:30 a.m. to review and approve the offer and is scheduled to issue its decision on August 30, 2012. L&M proposes to purchase the hospital and related entities for total consideration of $69,138,653 ("the Purchase Price"). The Purchase Price includes $6.5 million of working capital into the hospital during the first two years after the closing. These funds 1) will be used to continue the economic turnaround plan, subject to review and final approval by L&M, that was initiated by the Special Master and aimed at returning The Westerly Hospital to profitability and 2) include allocation of $1,850,000 to provide the equity for the proposed Geriatric-Psychiatric Program.

Exhibit F(7) provides monthly cash flow statements for 2013, 2014 and 2015.

ii. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs.

The $5.116M (less financing costs) of new capital investment will represent approximately 13.14% of total Net Hospital PPE of $38,948,661 as of April 30, 2012. The total cost of this proposal to the total value of the facility's physical plant, equipment, and health care services for both capital and operating costs is as follows:

	Project	**Entire Hospital**	**Combined**	**New Project %**
Capital Costs	5,942	33,491	39,433	15.07%
Operating Costs	1,934	46,953	48,887	3.96%

iii. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

The recently released BCBSRI small group Medical Expenses Trend Study compares these expenses to the CPI forecast less food and energy costs. This CPI forecast is a strong indicator of expected capital inflation. For the period beginning in 2013 and ending in 2016, the forecast projects this type of growth will decrease from 4% to 2% over the period. If accurate, this means that capital costs would increase approximately $103,000 during this period. This amount is covered by the various contingencies used in developing the project budget.

11.) Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20% equity investment in CON projects (33% equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	$1,850,000[+]	20%	0	0	Lawrence & Memorial Corporation
Debt**	$4,092,800	80%	6%	12 years	T/E Bond Issue
Lease**	$0	%	%		
TOTAL	**$5,942,800**	**100%**			

[+] **Includes all financing costs**

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete **Appendix F**.

12.) Will a fundraising drive be conducted to help finance this approval? Yes____ No **X**

13.) Has a feasibility study been conducted of fundraising potential? Yes___ No **X**

- If the response to Question 13 is 'Yes', please provide a copy of the feasibility study.

14.) Will the applicant apply for state and/or federal capital funding? Yes___ No **X**

- If the response to Question 14 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

15.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
		Equipment			
	Improvements	**Fixed**	**Moveable**	**Amortization**	**Total**
Total Cost	4,720.00	114.00	282.00	826.00	5,942.00
- Salvage Value	(472.00)	-	(14.10)	-	(486.10)
= Amount Expensed	4,248.00	114.00	267.90	826.00	5,455.90
/ Average Life	30.00	20.00	5.00	20.00	
= Depreciation	141.60	5.70	53.58	41.30	242.18

1 Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing
2 Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 18 (below).

16.) For the first full operating year of the proposal (identified in Question 18 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., $42,575=$43).

	Existing		**Additions/Reductions**		**New Totals**	
Personnel	**# FTEs**	**Payroll w/ Fringe**	**# FTEs**	**Payroll w/ Fringe**	**# FTEs**	**Payroll w/ Fringe**
Medical Director						
Physicians	4.04	1,206				
Administrator/Directors	14.42	2,523				
RN	142.67	15,772	6.80	649	149.47	16,421
LPN		-				
Nursing Aides	26.63	1,407	6.80	320	33.43	1,727
PT	15.60	1,534			15.60	1,534
OT	3.69	336			3.69	336
Speech Therapist	1.29	141			1.29	141
Clerical	118.63	7,308	1.00	43	119.63	7,351
Housekeeping	30.19	1,410	2.30	90	32.49	1,500
Dietary	19.80	1,055	1.60	67	21.40	1,122
Maintenance	11.35	889	0.30	17	11.65	906
Other Clinical	113.84	9,877	3.00	237	116.84	10,114
Other Non-Clinical	49.17	3,494	1.50	71	50.67	3,564
	551.29	46,953	23.30	1,494	578.59	48,446

The following FTEs are included in the "Other – Prof Fees Purch Svc, Travel, Education, Marketing" Expense Item in Table 18. The Payroll w/Fringe in the amount of 48,446 identified above is set forth in Table 18 in the "Payroll w/Fringe" expense item.

Included in Other Professional Fees						
Medical Director			1.00	100	1.00	100
Physician			1.00	150	1.00	150
Administrator/Directors			2.00*	190	2.00	190
Total Cost - Payroll and Other Prof Fees	**551.29**	**46,953**	**27.30**	**1,934**	**578.59**	**48,887**

***I/P and O/P Nurse Navigator**

1 Must equal the incremental “payroll w/fringes” expense in column -5-, Question 18 (below).

INSTRUCTIONS:

“FTEs” Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
“Additions” are NEW hires;
“Reductions” are staffing economies achieved through attrition, layoffs, etc. It does **NOT** report the reallocation of personnel to other departments.

17.) Please describe the plan for the recruitment and training of personnel.

South Shore and Gateway, in conjunction with TWH Human Resources Department, will provide for the recruitment, training and credentialing of personnel.

18.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., $112,527 = $113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., “depreciation” from Question 15 above, “payroll” from Question 16 above). If this proposal involved more than two separate “units of service” (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

			First Full Operating Year		
	Actual Previous Year 2011	Budgeted Current Year 2012	CON Denied	CON Approved	Incremental Difference
REVENUES					
Net Patient Revenue	83,304	80,592	83,397	87,285	3,888
Other	5,317	3,368	4,000	4,000	
Total Revenue	88,621	83,960	87,397	91,285	3,888
EXPENSES					
Payroll w/ Fringes	52,430	48,720	46,953	48,446	1,493
Bad Debt	6,782	7,253	7,505	7,505	
Supplies	11,373	11,683	12,089	12,581	492
Office Expenses	449	462	450	503	53
Utilities	1,562	1,422	1,465	1,526	62
Insurance	1,522	1,690	1,741	1,741	
Interest	1,411	716	760	1,006	246
Depreciation/Amortization	4,699	4,884	4,933	5,175	242
Leasehold Expenses	264	373	360	360	
Other-Prof fees, Purch Svc, Travel, Education, Marketing	13,335	14,482	13,758	14,715	957
Total Expenses	93,827	91,685	90,014	93,559	3,545
OPERATING PROFIT	(5,206)	(7,725)	(2,617)	(2,274)	343

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service Type: Patient Day	Geri-psych IP				
Service (#s): 4015					
Net Revenue Per Unit *8*	$	$	$	$	$879
Expense Per Unit	$	$	$	$	$811
Service Type: Patient Visit	Geri-psych OP				
Service (#s): 2250					2,250
Net Revenue Per Unit *8*	$	$	$	$	$160
Expense Per Unit	$	$	$	$	$128

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

1 The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column –3-.
2 Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.
3 Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.
4 Bad Debt is the same as that identified in column -4-.
5 Interest Expense equals the first full year's interest paid on debt.
6 Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.
7 Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;
8 Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

19.) Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Projected First Full Operating Year: FY 2013 Hospital including proposed inpatient geriatric psychiatric unit									
	Implemented			Not Implemented			Difference		
Payor Mix Inpatient	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	$	#	%	$	#	%	$
Medicare	13,657	68%	20,872,714	10,646	66%	18,132,528	3,011	75%	2,740,186
RI Medicaid	1,184	6%	1,798,233	838	5%	1,567,894	346	9%	230,340
Non-RI Medicaid	265	1%	478,177	209	1%	440,849	56	1%	37,327
RiteCare	6	0%	16,356	6	0%	16,356		0%	
Blue Cross	2,378	12%	6,239,378	2,085	13%	5,937,745	293	7%	301,633
Commercial	762	4%	1,452,622	678	4%	1,368,976	84	2%	83,646
HMO's	1,432	7%	3,855,898	1,307	8%	3,730,429	125	3%	125,469
Self Pay/Charity Care	512	3%	1,623,915	412	3%	1,615,042	100	2%	8,873
Other		0%			0%			0%	
TOTAL	20,196	100%	36,337,293	16,181	100%	32,809,819	4,015	100%	3,527,474

Outpatient	#	%		#	%		#	%	
Medicare	62,846	38%	12,553,722	60,821	38%	12,233,625	2,025	90%	320,097
RI Medicaid	10,531	6%	2,627,990	10,531	7%	2,627,990		0%	
Non RI Medicaid	886	1%	398,114	886	1%	398,114		0%	
Rite Care	6	0%	6	6	0%	6		0%	
Blue Cross	42,573	26%	15,211,915	42,573	26%	15,211,915		0%	
Commercial	12,235	7%	4,365,201	12,235	8%	4,365,201		0%	
HMO	28,055	17%	11,644,164	27,830	17%	11,603,713	225	10%	40,451
Self Pay/charity	6,700	4%	4,146,617	6,700	4%	4,146,617		0%	
Other		0%			0%			0%	
Total	163,832	100%	50,947,729	161,582	100%	50,587,181	2,250	100%	360,548
Grand Total	184,028		87,285,022	177,763		83,397,000	6,265		3,888,022

Projected First Full Operating Year: FY 2013 Inpatient Geriatric Psychiatric – Also included In Hospital Projected First Full Operating Year: FY 2013 above									
	Implemented			Not Implemented			Difference		
Payor Mix	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	$	#	%	$	#	%	$
Medicare	3,011	75%	2,740,186	0	0	0	3,011	75%	2,740,186
RI Medicaid	346	9%	230,340	0	0	0	346	9%	230,340
Non-RI Medicaid	56	1%	37,327	0	0	0	56	1%	37,327
RiteCare		0%		0	0	0		0%	
Blue Cross	293	7%	301,633	0	0	0	293	7%	301,633
Commercial	84	2%	83,646	0	0	0	84	2%	83,646
HMO's	125	3%	125,469	0	0	0	125	3%	125,469
Self Pay/Charity Care	100	2%	8,873	0	0	0	100	2%	8,873
Other		0%			0			0%	
TOTAL	4,015	100%	3,527,474	0	0	0	4,015	100%	3,527,474

See Schedule at Tab 7, including outpatient geriatric psychiatric data (revenue included in question 18 table).

20.) Please provide the following:

A. Please provide audited financial statements for the most recent year available.

Consolidated, audited financial statements FYE September 30, 2010 and September 30, 2009 are attached at Tab 2. There are no FYE11 audited financial statements and the hospital does not anticipate that any will be completed. At the time of the Mastership filing (December 7, 2011) the FYE2011 external audit was being finalized. The auditors indicated that they would be issuing a "going concern" statement as part of the audit. When the hospital filed for mastership, the auditors demurred to complete the audit and it is unlikely that they would consider doing so at this time. In addition, they are owed considerable money by the hospital which further complicates the issue. Please see the unaudited financial statements of the hospital for FYE2011 Unaudited 12-Month Financials as of 12/31/11 and Unaudited Financials 7 Months Ending May 31, 2012 at Tab 2.

B. Please discuss the impact of approval or denial of the proposal on the future viability of the (1) applicant and (2) providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

1. **TWH – In today's health care economy, a small community hospital such as The Westerly Hospital remains viable only if it is providing its community with the services that are clearly needed. As described earlier in this proposal, a review of the health care needs of our community clearly indicate a need for the availability of in and outpatient mental**

health services in the local community. Our aging population will make the need for Geriatric Psych care even more acute over the next several years. If our proposal is accepted, the community will soon have an outstanding new mental health service available, without the need for lengthy travel within the state and without having to house local patients in an inappropriate setting such as a nursing home bed or acute care hospital bed (as happens now). If denied, TWH will lose the opportunity to retain some of its community support because we could not then offer this vital service. Patients will be forced to suffer the inconveniences described above, and both TWH and the local community become less attractive.

2. **Other providers - There is a real lack of these services in the South County market. This is clearly demonstrated in the response of the mental health professionals and interested community members described in Question # 18. The only other acute care hospital in this market has supported our proposal in the past and the facilities that now provide much of the other necessary services clearly see the need for the program we are proposing as "filling out" the full spectrum of needed mental health care. They all recognize that at present, a patient needing our proposed services in this market faces the choice of either traveling a considerable distance to find an appropriate facility or being boarded in a facility not designed to deliver state-of-the-art hospital-based mental health services.**

21.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

This unit will be a totally new service provided by the hospital in a newly designed 12,000 square foot building on the campus. As such it isn't possible for the hospital to identify the operating efficiencies it will generate. The plant has been designed for maximum efficiency of staff (one nursing unit covers the floor) and non-clinical space has been kept to a minimum. In addition, it will be fully capable of interfacing electronically with the main hospital and others. TWH plans to report on efficiencies of this new operation after the initial 12 months of operation. Accordingly, at this time, there are no quantifiable derivable operating efficiencies.

22.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

The energy modeling of this new facility has been carefully considered. The design criteria includes meeting the qualifications for the US Environmental Protection Agencies Energy Star ratings for hospitals with an equivalent score of 75 on a scale of 100. In order to achieve this goal, consumption of electrical energy, heating oil/natural gas and water consumption must use the most advanced engineering methods available. Our modeling indicates that we will have energy expenditures of $5.07 dollars per square foot for all the above utilities combined. This achievement will place us well above our target benchmark of an Energy Star Score of 75. While this score will likely quality us for LEEDS certification, the hospital will probably not apply for it because of the high cost of obtaining the certification.

23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the

circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

This proposal will allow the reallocation of current patient service expenses to the more appropriate point of service, which speaks to the all-important moral obligation of the State, to allow for adequate and appropriate care to be provided to its citizens. We believe this obligation must always be primary when the State evaluates new healthcare service proposals. The reimbursement for this service will be largely funded by Federal rather than State monies. 68% of the served population will be Medicare patients (100% Federal) and 8% will be Medicaid patients (50% Federal) another 11% will be out-of-state private insurance. Over 82% of the operating costs of this unit will be borne by non-Rhode Island payers. Accordingly, this proposal should not impact the state's budget in a negative manner and it is affordable.

At least in the South County marketplace, the hospital anticipates substantially reduced costs associated with these patients being held in Emergency Departments (or even worse placed in an acute care bed) because there is no place that can take the Geri-psych patients (all other units operate at 90% average occupancy).

Accordingly, notwithstanding the current condition of the state's troubled economy, including increased unemployment rates, this proposal, primarily funded by federal monies, should result in reduced costs for the targeted patient population thereby minimizing any adverse impact on Rhode Island's economy.

QUALITY, CONTINUITY OF CARE, AND RELATIONSHIP TO THE HEALTH CARE SYSTEM

24.) **A) If the applicant is an existing facility:**

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

None

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

N/A

C) If this proposal involves construction or renovation:

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

There will be no temporary move of a facility or service necessitated by the proposed construction or renovation.

25.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal.

The neighborhood and the community to be served will be impacted in at least three ways by this new service:

1. **Service availability- Despite the demonstrated need for the service in our community, there are currently no beds locally available to meet this need. While some ambulatory counseling services are available in the community, there are none that provide the scope and intensity of these services rendered in an acute care hospital setting. The first impact is that this service will now be available to the community without the need for extensive travel or crossing State lines.**

2. **The second impact will be economic, the new service will create an estimated 17.3 new health care jobs in the community. These are well paying jobs which will provide a small, but real economic boost to the South County Community**

3. **The neighborhoods close to the facility will see little direct impact from the new addition to the hospital for a number of reasons:**

    - **The addition to be constructed is relatively small (12,000 sq ft), less complicated than an acute hospital unit, and it will be constructed solely within the current footprint of the Hospital Campus.**
    - **The unit will be dedicated to the treatment of Geriatric patients and will be located mid-campus. Adequate parking will be provided. No additional noise or parking intrusion will be experienced by the neighborhood.**
    - **All parking spaces removed by this construction will be replaced on the campus.**
    - **Additional water and sewage needs will be met through the construction requirements.**

26.) Please discuss the impact of the proposal on service linkages with other health care facilities/providers and on achieving continuity of patient care.

The opening of Geri-psychiatric beds will provide much needed care and help to the nursing homes and day care services in the area. Working with the local nursing homes, patients identified with various psychiatric needs will be able to locally obtain care that currently is unavailable. This proposal will permit a focused treatment and intervention for elderly patients experiencing psychiatric symptoms of a primary diagnosis or resultant from organically based problems. Currently, these patients admitted for medical issues from nursing homes are intermingled in the medical units and do not obtain the focused intensive services that will be delivered on a specialized unit. On an outpatient basis, the Adult Day Center of Westerly provides services to allow elderly patients to stay in a home setting, yet the organization is limited since there are no outpatient services specific to meet the needs of this geriatric population. The distance to the existing programs from the greater Westerly community creates a substantial impediment for very elderly patients and their families whom need to access such services. Psychiatric intake assessments of the elderly require an initial assessment in all, but the most critical circumstances where a patient is deemed to be an imminent threat to self or others. This initial assessment, done on an outpatient basis, may involve multiple evaluations over several days, again, making physical distance a primary variable in the ability to access care. TWH will also continue and possibly expand its relationship with South Shore Mental Health Center to meet the needs of this population as well as others. South Shore currently provides psychiatric evaluations and, if necessary, certifications on patients as requested. Certification is necessary to obtain a psychiatric bed if needed. South Shore will play an increased role and provide service linkage in professional services for the organized outpatient program and the inpatient geriatric psychiatric program.

27.) Please address the following:

A. How the applicant will ensure full and open communication with their patients' primary care providers for the purposes of coordination of care;

As a small community health care organization, The Westerly Hospital has various existing vehicles of communication that are already in place that ensure efficient communication with the primary and specialty care physicians. The most recent initiative underway is the implementation of a new fully integrated EMR system through McKesson Paragon that allows physician offices to access not only diagnostic results, but review of documentation of inpatient and outpatient hospital delivered services. It is the intent that the Geriatric psychiatric program will be added to the Mckesson Platform as an additional clinical population and care site and, therefore, become part of the overall patient EMR, available to the primary and specialty care physicians. Physicians that may not be part of TWH system will be able (with the proper consents) to receive electronic versions of any requested clinical information.

B. Discuss the extent to which preventive services delivered in a primary care setting could prevent overuse of the proposed facility, medical equipment, or service and identify all such preventative services;

There are no (direct) preventive services delivered in a primary care setting that could prevent overuse of the Geriatric Psychiatric service. However, referral by the primary care physician for outpatient psychiatric evaluation and active engagement with behavioral and pharmaceutical treatment regimes could stabilize a patient in the community and/or define the need for an inpatient hospitalization (and stabilization of a critical psychiatric event).

C. Describe how the applicant will make investments, parallel to the proposal, to expand supportive primary care in the applicant's service area.

There is no specific investments planned in parallel with this proposal.

D. Describe how the applicant will use capitalization, collaboration and partnerships with community health centers and private primary care practices to reduce inappropriate Emergency Room use.

The continued growth strategy for primary care practices using the vehicle of TWH affiliate Atlantic Medical Group ("AMG") will continue to place primary care physicians throughout our primary catchment area. As practices are developed and capacity to deliver primary and preventive services increase in the community setting, the inappropriate use of the Emergency Department should be reduced.

Atlantic Medical Group, Inc., a Rhode Island non-profit corporation ("AMG"), has the same parent company as the hospital. The purpose of AMG initially was to assist in the recruitment of physicians who wanted to be employed versus opening an individual practice. The future purpose is to prepare for health care reform. The physician alignment created

through this company will provide opportunities to improve the continuity of care, roll out bundled payments and institute well care models as they become a reality.

E. Identify unmet primary care needs in your service area, including "health professionals shortages", if any (information available at Office of Primary Care and Rural Health at http://www.health.ri.gov/disease/primarycare/hpsa-professionals.php).

This proposal will enhance the continuity of geriatric patient care in the patient's appropriate community hospital setting in concert with the patient's primary care physician. In April 2012, TWH commissioned a study to determine the need for physicians in the general Westerly marketplace. A copy of that study is attached at Tab 8. (There is no final version of the study.) The study focused heavily on the need for primary care physicians in the market and as noted in Table #2, contained within the report. The market is short some 11.5 primary care physicians (I/M, FP, Peds and OB/GYN), as well as 2.4 specialists. Table #3 looks at this shortfall by community. Table #4 indicates that a number of the current local physicians (7) are over 65 years of age.

28.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state.

The services proposed herein will enhance the services now provided by the State's healthcare system in a number of ways: Rhode Island's mental health system can be generally characterized as being comprised of a public community mental health center system and private sector providers including hospitals and individual practitioners.

Community Mental Health System. The CMHC system is primarily focused on providing services to individuals with disabilities:

- **Persons with serious and persistent mental illness ("SPMI"), emotional difficulty and psychological disorders;**
- **Those individuals with developmental disabilities which are attributable to a cognitive or physical impairment; and**
- **Persons with a problem of substance abuse that is chronic, progressive and relapsing and results in physical and psychological dependence on chemical substances.[22]**

While the compact size of Rhode Island and the regional structure of the community mental health center ("CMHC") network would tend to mitigate distance as an access issue for the general adult population, the same is not necessarily true for the geriatric population.

While Rhode Island's CMHC network is generally comprehensive in nature, services provided to the geriatric population appear to be somewhat limited, particularly in the South County Region. Services have been historically focused on the needs of children, adolescents and adult populations. This is evidenced by the fact that 10.2% of the total patients treated by Rhode Island CMHC's in

[22] Combined Substance Abuse and Mental Health Plan 2012-2013, DBHDDH, September 1, 2011, page 24.

2009 were geriatric. In comparison, the 2010 U.S. census reported that 14.5% of Rhode Island's population were persons 65 years or older. For the South Shore Mental Health Center which is the CMHC serving the south county region, only 7.7% of the patients were persons 65 years or older.[23] There are a variety of factors impacting utilization of behavioral health by geriatric populations. These factors include:

- **Distance to services. Studies have indicated that the proximity of mental health services to a geriatric's source of primary care impacted access and utilization. CMHC's do not routinely provide the range of primary medical services needed to treat the co-morbid geriatric patient population. As a result, the geriatric patient would have to seek behavioral health and medical services in separate locations. The greater the distance the higher the rate of disengagement.[24]**

- **The targeting of mental health services to specialized groups that exclude the elderly. As indicated by their Mission; the CMHC system is focused on addressing the needs of the SPMI population which generally excludes the elderly. The geriatric population has historically attached a "stigma" to programs treating the chronic mentally ill population. Studies have indicated that the geriatric population will not readily utilize programs treating SPMI populations.[25]**

In summary, the existing CMHC system, while providing high levels of quality treatment to its target population is not focused on addressing the needs of the geriatric population.

Private Sector Hospitals and Practitioners. The proposed hospital-based inpatient and outpatient behavioral health program will provide a needed continuum of geriatric (and adult) psychiatric services to a service area where the closest inpatient programs are located at Kent Hospital in Warwick and Newport Hospital in Newport which are located approximately twenty-five (25) miles from Westerly. The existing behavioral health services associated with Kent Hospital include a 20-bed general adult inpatient psychiatric unit and a 20-bed inpatient unit at Butler Hospital in Providence. In the aggregate, these inpatient units experienced an FY 2009 ADC of 35.2 patients (88.1% occupancy) including a geriatric ADC of 0.9 patients. Newport Hospital's behavioral health services include a fifteen (15) bed general adult inpatient unit. In FY 2009, these beds experience an overall reported ADC of 10.9 patients (72.4% occupancy) including a geriatric ADC of 1.2 patients.

In conclusion, the proposed services will prove access for an important patient population, i.e., the geriatric population in need of psychiatric services and will coordinate care with South Shore Center.

[23] Zimmerman, Tables 10A and 11A, page 26.
[24] Bartels, S.J., MD, Coakley, E.H., MPH, et. al., Improving Access to Geriatric Mental Health Services: A randomized Trial Comparing Treatment Engagement with Integrated Versus Enhanced Referral Care for Depression, Anxiety and At-Risk Alcohol Use, American Journal of Psychiatry, 2004; 161:1455-1462.
[25] Department of Health and Human Services, Administration on Aging, Older Adults and Mental Health: Issues and Opportunities, January 2001.

Select and complete the Appendixes applicable to this application:

Appendix	Check off:	Required for:
A	√	Accelerated review applications
B	√	Applications involving provision of services to inpatients
C		Nursing Home applications
D	√	**All applications**
E		Applications with healthcare equipment costs in excess of $1,000,000 and any tertiary/specialty care equipment
F	√	Applications with debt or lease financing
G	√	**All applications**

Appendix A
Request for Expeditious Review

1.) Name of applicant: **The Westerly Hospital**

2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X'.

_____a. for emergency needs documented in writing by the state fire marshal or other lawful authority with similar jurisdiction over the relevant subject matter;

_____b. for the purpose of eliminating or preventing fire and/or safety hazards certified by the state fire marshal or other lawful authority with similar jurisdiction of the relevant subject matter as adversely affecting the lives and health of patients or staff;

_____c. for compliance with accreditation standards failure to comply with which will jeopardize receipt of federal or state reimbursement;

X d. for such an immediate and documented public health urgency as may be determined to exist by the Director of Health with the advice of the Health Services Council.

3.) For each response with an 'X' beside it in Question 2 above, furnish documentation as indicated:

2.a: a written communication from the State Fire Marshal or other lawful authority with similar jurisdiction over the relevant subject matter setting forth the particular emergency needs cited and the measures required to meet the emergency;

2.b: documentation from the State Fire Marshal or other lawful authority with similar jurisdiction of the relevant subject matter certifying that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;

2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations failure of compliance with which will jeopardize receipt of federal or state reimbursement;

2.d: a complete description and documentation of the immediate and documented public health urgency, which, in the applicant's opinion, necessitates an expeditious review.

TWH is currently in state mastership proceedings pursuant to an order of the Superior Court (J. Stern) entered on December 12, 2011. The Special Master has filed a Petition for Instructions regarding the presentation and acceptance of a stalking horse offer scheduled for hearing on June 13, 2012 at 2:00 p.m. (the "Petition"). The Petition seeks approval, among other things, for authority to accept an offer made by LMW Healthcare, Inc. and LMW Physicians, Inc., whose obligations thereunder are guaranteed by Lawrence & Memorial Corporation (collectively, "L&M"), subject to higher and better offers as set forth in the form of an Asset Purchase Agreement attached to the Petition. In addition, the Special Master is proposing that after a stand-

still period, up to and until July 30, 2012, within which L&M may resolve non-regulatory contingencies, the Special Master can thereafter negotiate with competitive bidders. Finally, the timetable by which the Court would consider highest and best bids at a sale hearing is targeted for August 13, 2012.

Accordingly, the timetable proposed by the Special Master contemplates a decision by the Court in August, 2012 to determine the highest and best offer for TWH and related entities. The proposed geri-psych unit is an integral part of the hospital, will address the unmet needs of its patient population and will serve to enhance the value of the hospital when reviewed by potential bidders. Accordingly, it is essential, in order to ensure the continued viability of TWH, a needed community hospital, that the Certificate of Need Application be reviewed and decided on an expedited basis.

Appendix B

Provision of Health Services to Inpatients

1. Are there similar programmatic alternatives to the provision of institutional health services as proposed herein which are superior in terms of:

   a. Cost ___ Yes **X** No
   b. Efficiency ___ Yes **X** No
   c. Appropriateness ___ Yes **X** No

2. For each No response in Question 1, discuss your finding that there are no programmatic alternatives superior to this proposal separately for each such finding.

   TWH's findings as set forth above reflect the hospital's opinion including the lack of any comparable program in its service area and the high utilization of inpatient psychiatric units outside its service area consistent with the findings of Diamond Healthcare Corporation.

   Cost: No superior cost alternatives – the hospital has no comparative data available to allow it to demonstrate this factor.

   Efficiency: The hospital can find no comparative data to use in making such an analysis. However, the proposed new unit will be a state- of- the- art facility designed for maximum efficiency for treating both in and outpatient geriatric patients. There is no comparable facility in the state.

   Appropriateness: This facility will be specifically designed and tailored to meet the needs of the geriatric psychiatric patient. All of the services and the clinical environment recommended to treat this specific type of patient will be available and in place. We believe this unit will be the "most appropriate" one in the State to treat the Geriatric Psych Patient. The hospital has no specific supporting documentation.

3. For each Yes response in Question 1, identify the superior programmatic alternative to this proposal, and explain why that superior alternative was rejected in favor of this proposal separately for each such finding.

4. In the absence of proposed institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of:

   a. Availability **X** Yes ___ No
   b. Accessibility **X** Yes ___ No
   c. Cost **X** Yes ___ No

5. For each Yes response in Question 4, please justify and provide supporting evidence separately for availability, accessibility and cost.

TWH's findings as set forth above reflect the hospital's opinion including the lack of any comparable program in its service area, and the high utilization of inpatient psychiatric units outside its service area consistent with the findings of Diamond Healthcare Corporation.

Availability: Based upon The Westerly Hospitals ED experience, the Geriatric Psych patient often has difficulty being placed in an available Psychiatric bed: (i) occupancy levels run very high in these units (90%) and often there are no beds available - often for days, (ii) even the closest available units are a considerable distance away (25-30 miles) – this is important for a population that has difficulty with extended travel; and (iii) none of the closest units are operated specifically for the geriatric patient, often the patient is housed in a unit that is mostly the general psych population – these are very different patients from the geriatric population.

Accessibility: The distance that the average Westerly service area geriatric resident must travel to receive inpatient or hospital-based outpatient services is a considerable barrier to these patients. Many don't drive and their support system is limited in terms of getting back and forth from the facility. Others can drive but are often limited to shorter distances and "daylight only" driving due to vision problems. The local area has excellent facilities for transporting the elderly but these services tend to be limited to routes that serve only the local markets.

Cost: The hospital has no data from other hospitals in order to make this comparison.

Appendix D

All applications must be accompanied by responses to the questions posed herein.

1. Provide a description and schematic drawing of the contemplated construction or renovation or new use of an existing structure and complete the Change in Space Form.

Please find attached Tab D1 which is a schematic drawing of the floor plan. The building will be a single story structure attached to the main hospital which provides for ancillary services to be available, as well as for patient transport. The structure will include reception, inpatient rooms both semi-private as well as private, clinical support space, as well as administrative support. Outpatient counseling space separate from the inpatient treatment areas are also included in the design. A secure courtyard is included in the interior of the building which allows for patient interaction and a healthy treatment environment.

Finally, the proposed building is a 12,000 square foot single-story structure housing inpatient/outpatient services for the Geriatric Behavioral Health Unit. The design intent of the exterior and the interior of the building is to create an aesthetically pleasing atmosphere for patients to encourage their healing process. The building infrastructure, such as chilled water, steam, main power and emergency power, will be provided from the main hospital systems.

2. Please provide a letter stating that a preliminary review by a licensed architect indicates that the proposal is in full compliance with the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number. **See Tab D2.**

3. Provide assurance and/or evidence of compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

The Applicant will comply with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes____ No_X_

- If Yes, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.

5. Describe all the alternatives to construction or renovation which were considered in planning this proposal and explain why these alternatives were rejected.

TWH reviewed existing hospital space; however, there is inadequate space available to meet the needs of this program. In addition, renovation costs for the existing space is cost-prohibitive. TWH also reviewed a stand-alone facility, whose prohibitive costs and lack of efficiencies made it an

unreasonable alternative. As noted in response to Question 7G, three basis alternative proposals evaluated included:

1. **Renovate space within the main hospital: This proved impossible for two reasons; 1.) There was no contiguous space large enough to meet the needs of the unit within the main hospital building and; 2.) If there were space, early estimates of both the costs (and the unforeseeable costs) of renovating within the main building were know to be prohibitive (from looking at other projects). Finally, there are currently no unoccupied nursing units at TWH.**
2. **Using available land, build a separate stand-alone facility to house the program. This would essentially be a separate small hospital sharing the Campus. Again, initial cost estimates for this type of approach were prohibitive.**
3. **Create an attached or nearby related building that would contain only the clinical space needed for the Program. This building would not have the infrastructure of a stand-alone hospital (dietary, laundry, support services, etc) and would serve as a clinical extension of the main hospital. The initial plan was to attach this unit to the building, but topographical considerations make it less expensive to connect the building to the current hospital via a short, covered walkway.**

Alternative 3 was ultimately selected as providing the most benefit for the least cost.

6. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project.

See Tab D6.

7. If zoning approval is required, attach evidence of application for zoning approval. **N/A**

8. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal.

See Tab D8.

9. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

Within 30 days of contract award.

10. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented. If this service will be phased in, describe what will be done in each phase.

October, 2013

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration and use of space in your facility.

Column 1
Column 1 is used to identifying discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

a.) to utilize newly constructed space
b.) to utilize renovated or modernized space
c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2
For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3
For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4
For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5
For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6
For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7
Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form

Please identify and provide a definition for the method used for measuring the space (i.e. gross square footage, net square footage, etc.):

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
Geri-Psych Inpatient Suite	0	12,000	0	0	12,000	12,000
TOTAL:	0	12,000	0	0	12,000	12,000

Appendix F

Financing

Applicants contemplating the incurrence of a financial obligation for full or partial funding of a certificate of need proposal must complete and submit this appendix.

1. Describe the proposed debt by completing the following:
   a.) type of debt contemplated: Tax Exempt Bond Issue
   b.) term (months or years): 20 years
   c.) principal amount borrowed $4,092,800
   d.) probable interest rate 6%
   e.) points, discounts, origination fees 2.5%
   f.) likely security Hospital Plant
   g.) disposition of property (if a lease is revoked) N/A
   h.) prepayment penalties or call features 5 years
   i.) front-end costs (e.g. underwriting spread, feasibility study, legal and printing expense, points etc.) $30,000
   j.) debt service reserve fund $450,208 (1 year)

2. Compare this method of financing with at least two alternative methods including tax-exempt bond or notes. The comparison should be framed in terms of availability, interest rate, term, equity participation, front-end costs, security, prepayment provision and other relevant considerations.

While TWH believes that the lowest cost method of financing this project would be the issuance of T/E Revenue bonds, the hospital is exploring two additional financing vehicles:

1. Bank Loan: Using the unencumbered plant as security TWH would seek proposals from at least 2 local banks to provide mortgage financing for the project (15-20 year). Would like an extended amortization schedule. The Geri-Psych unit itself will be able to service the debt shortly after start-up. We have begun to solicit interest from local banks on this matter
2. Developer –Lease Financing: A healthcare real estate development firm would construct the building for the Hospital and lease it on a long-term basis to the Hospital. The term of the Lease would likely be co-terminus with the loan terms of the developer's underlying borrowing terms. The Hospital is actively soliciting interest from potential developers.

While TWH is still in mastership, it recognizes that many financial institutions may shy away from soliciting our business. However, the project itself is highly attractive as an investment and the hospital is well into its turnaround and where it will once again be seen as a "bankable" entity. Due to TWH's status in mastership, it cannot presently obtain another method of financing; however, any interest rate would most likely be in the 11% range in a turn-key operation in which the hospital leases the building back.

3. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated. **N/A**

4. Present evidence justifying the refinancing in Question 3. Such evidence should show quantitatively that the net present cost of refinancing is less than that of the existing debt, or it should show that this project cannot be financed without refinancing existing debt. **N/A**

5. If lease financing for this proposal is contemplated, please compare the advantages and disadvantages of a lease versus the option of purchase. Please make the comparison using the following criteria: term of lease, annual lease payments, salvage value of equipment at lease termination, purchase options, value of insurance and purchase options contained in the lease, discounted cash flows under both lease and purchase arrangements, and the discount rate. **N/A**

6. Present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.

Principal Dollars Borrowed	**$4,908,290**	**(includes Financing Costs)**
Total Interest Paid	**2,944,974**	**(20 year amort)**
Total Debt Service	**7,853,264**	
Annual Level D/S Payment	**$ 392,663**	
Monthly D/S Payment	**$ 32,722**	

Debt Service

Face Amount of Bonds: **$4,908,920**

Average Coupon Rate: **6%**

Annual Payments	**Year**	
Begin 2013	**1**	**392,663**
	2	**392,663**
	3	**392,663**
	4	**392,663**
	5	**392,663**
	6	**392,663**
	7	**392,663**
	8	**392,663**
	9	**392,663**
	10	**392,663**
	11	**392,663**
	12	**392,663**
	13	**392,663**
	14	**392,663**
	15	**392,663**
	16	**392,663**
	17	**392,663**
	18	**392,663**
	19	**392,663**
End 2033	**20**	**392,663**
Total Payments		**7,853,260**

7. Please include herewith an annual analysis of your facility's cash flow for the period between approval of the application and the third year after full implementation of the project.

   See Tab F7.

Appendix G

Ownership Information

All applications must be accompanied by responses to the questions posed herein.

1. List all officers, members of the board of directors, trustees, stockholders, partners and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

   W. Mark Russo, Esq., Ferrucci Russo P.C., 55 Pine Street, 4th Floor, Providence, RI 02903, is the duly appointed Special Master for The Westerly Hospital and its sole shareholder, Westerly Hospital Healthcare, Inc., pursuant to an order of the Rhode Island Superior Court (J. Stern).

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

   None.

3. If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

   None.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes___ No **X** .

   - If response is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant. **See Tab G5.**

6. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 5 above (applicant and/or its principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

The Westerly Hospital, License No. 112, Medicare Provider No. 410013, DNV accredited

Westerly Clinical Support Services, License No. PLS00455

7. Have any of the facilities identified in Question 5 or 6 above had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license? Yes ___ No **X**

- If response is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.

8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes **X** No___

- If response is 'Yes', please identify the facility and its current status.

See response to Question 1 above.

9. For applications involving establishment of a new entity or involving out of state entities, please provide the following documents:

- Certificate and Articles of Incorporation and By-Laws (for corporations)
- Certificate of Partnership and Partnership Agreement (for partnerships)
- Certificate of Organization and Operating Agreement (for limited liability corporations)

N/A

Exhibit 1

STATE OF RHODE ISLAND
WASHINGTON, SC.

SUPERIOR COURT

CHARLES S KINNEY, CHIEF EXECUTIVE OFFICER AND TRUSTREE
Plaintiff

v.

C.A. No. 2011-0781

WESTERLY HOSPITAL HEALTHCARE, INC., THE WESTERLY HOSPITAL, ATLANTIC MEDICAL GROUP, INC, OCEAN MYST, MSO LLC, WOMEN'S HEALTH OF WESTERLY, LLC, AND NORTH STONINGTON HEALTH CENTER, INC.
Defendant

ORDER

This matter having come before the Court on the 18th day of July, 2012, on the Permanent Special Master's Petition for Instructions Regarding a Certificate of Need Application to Establish a Geriatric Psychiatry Unit at the Westerly Hospital.

Upon consideration of the Petition, representations by the Special Master, and presentation by the State of Rhode Island Department of Attorney General, it is hereby:

ORDERED, ADJUDGED AND DECREED

1. The Special Master's Petition for Instructions regarding a Certificate of Need Application to Establish a Geriatric Psychiatry Unit at the Westerly Hospital is hereby granted;
2. The Court holds that the Special Master was correct in seeking authority to pursue the expansion of services at the Hospital in light of the Mastership proceedings. Notwithstanding, the Court's granting of the instant Petition does not in any way impact the jurisdiction and authority of the applicable regulatory bodies in reviewing and acting upon the application for a Certificate of Need; and

3. The Special Master, as represented in his presentation, shall return to the Court for further authority prior to the implementation of the Geriatric Psychiatry Unit in the event that the Certificate of Need is granted by the appropriate regulatory authorities

ENTERED as an Order of this Court this 27th day of July, 2012.

PER ORDER:

Clerk
Dated: 7.27.12

ENTER:

Associate Justice
Dated: 7.27.12

Submitted by:

W. Mark Russo (#3937) Permanent Special Master
for Westerly Hospital Health Care, Inc.,
The Westerly Hospital, Atlantic Medical Group, Inc.,
Ocean Myst MSO, LLC, Women's Health of Westerly,
LLC, and North Stonington Health Center, Inc.,
and not in his individual capacity
Ferrucci Russo P.C
55 Pine Street, 4th Fl.
Providence, RI 02903
Telephone: (401) 455-1000
Facsimile: (401) 455-7778
Dated: July __, 2012

k \w\westerly hospital\pleadings\order sm's petition for instructions regarding certificate of need application for geriatric psychiatry unit docx

Exhibit 2

THE WESTERLY HOSPITAL AND SUBSIDIARY

(A Controlled Affiliate of Westerly Hospital Health Care, Inc.)

COMBINED FINANCIAL STATEMENTS

SEPTEMBER 30, 2010 AND 2009

THE WESTERLY HOSPITAL AND SUBSIDIARY
(A Controlled Affiliate of Westerly Hospital Health Care, Inc.)

CONTENTS

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BlumShapiro

Accounting | Tax | Business Consulting

Independent Auditors' Report

The Board of Trustees
The Westerly Hospital and Subsidiary

We have audited the accompanying combined balance sheets of The Westerly Hospital and Subsidiary (the Hospital) (a controlled affiliate of Westerly Hospital Health Care, Inc.) as of September 30, 2010 and 2009, and the related combined statements of operations and changes in net assets and cash flows for the years then ended. These combined financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these combined financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit also includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of The Westerly Hospital and Subsidiary as of September 30, 2010 and 2009, and the results of their operations and changes in net assets and their cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Blum, Shapiro & Company, P.C.

March 3, 2011

THE WESTERLY HOSPITAL AND SUBSIDIARY
(A Controlled Affiliate of Community Health of Westerly, Inc.)
COMBINED BALANCE SHEETS
SEPTEMBER 30, 2010 AND 2009

ASSETS

	2010	2009
Current Assets		
Cash and cash equivalents	$ 2,413,242	$ 2,951,166
Patient accounts receivable, net	7,336,470	7,459,592
Inventories	1,611,752	1,469,759
Other current assets	1,166,569	876,919
Total current assets	12,528,033	12,757,436
Assets Limited as to Use		
Promises to give, net	11,950	108,554
By Board to function as endowment	12,368,211	11,296,158
Under loan agreement, funds invested by trustee	1,963,570	1,896,847
Accumulated earnings on permanent endowment funds	3,513,444	3,379,358
By donors or grantors for specific purposes	301,614	364,595
By donors for permanent endowment funds	4,744,092	4,671,877
Funds held in trust	7,556,551	7,290,244
Total assets limited as to use	30,459,432	29,007,633
Other Assets		
Property, plant and equipment, net	36,501,015	38,296,354
Deferred financing costs, net	209,899	233,389
Due from related party, long-term	869,589	1,119,299
Other long-term assets	513,420	598,371
Total other assets	38,093,923	40,247,413
Total Assets	$ 81,081,388	$ 82,012,482

The accompanying notes are an integral part of the combined financial statements

LIABILITIES AND NET ASSETS

	2010	2009
Current Liabilities		
Lines of credit	$ 4,566,767	$ 2,433,264
Current installments of long-term debt	984,831	925,659
Current installments of capital lease obligations	2,326,753	1,612,283
Accounts payable and accrued expenses	5,739,354	5,149,870
Deferred revenue	1,469,601	118,545
Accrued payroll, benefits and related taxes	3,927,424	5,087,264
Estimated third-party payor settlements	872,367	879,073
Total current liabilities	19,887,097	16,205,958
Long-Term Liabilities		
Long-term debt, net of current portion	12,788,366	13,768,276
Long-term portion of capital lease obligations	1,406,509	2,932,268
Noncurrent accrued pension cost	20,456,320	16,257,162
Asset retirement obligation	1,412,870	1,389,257
Total liabilities	55,951,162	50,552,921
Net Assets		
Unrestricted	9,002,516	15,644,933
Temporarily restricted	3,827,067	3,852,507
Permanently restricted	12,300,643	11,962,121
Total net assets	25,130,226	31,459,561
Total Liabilities and Net Assets	$ 81,081,388	$ 82,012,482

THE WESTERLY HOSPITAL AND SUBSIDIARY
(A Controlled Affiliate of Community Health of Westerly, Inc.)
COMBINED STATEMENTS OF OPERATIONS AND
CHANGES IN NET ASSETS
FOR THE YEARS ENDED SEPTEMBER 30, 2010 AND 2009

	2010	2009
Unrestricted Revenue		
Net patient revenue	$ 90,460,251	$ 87,786,337
Other revenue	1,809,187	1,356,297
Total revenues	92,269,438	89,142,634
Expenses		
Salaries and benefits	51,825,334	48,398,951
Supplies and other expenses	29,384,660	28,549,604
Depreciation	4,592,213	4,450,501
Provision for uncollectible accounts, net	5,962,284	7,249,449
Interest	1,306,259	1,377,482
Total expenses	93,070,750	90,025,987
Loss From Operations	(801,312)	(883,353)
Nonoperating Income		
Interest and investment income	448,102	(400,439)
Unrestricted gifts and bequests	819,506	594,091
Total nonoperating income	1,267,608	193,652
Excess (Deficiency) of Revenues and Gains over Expenses	466,296	(689,701)

(Continued on next page)

THE WESTERLY HOSPITAL AND SUBSIDIARY
(A Controlled Affiliate of Community Health of Westerly, Inc.)
COMBINED STATEMENTS OF OPERATIONS AND
CHANGES IN NET ASSETS (CONTINUED)
FOR THE YEARS ENDED SEPTEMBER 30, 2010 AND 2009

	2010	2009
Other Changes in Unrestricted Net Assets		
Net assets released from restrictions	$ 552,981	$ 642,793
Capital transactions with affiliates	(4,915,318)	(3,121,653)
Change in unrealized gains on investments	443,946	386,985
Changes in additional minimum pension liability	(3,190,322)	(4,854,582)
Cumulative effect of change in accounting principle	-	(1,953,342)
Decrease in unrestricted net assets	(6,642,417)	(9,589,500)
Temporarily Restricted Net Assets		
Investment income	1,015	1,018
Net realized gains on investments	109,469	192,048
Net unrealized gains (losses) on investments	345,450	(168,208)
Gifts and bequests	41,840	95,153
Pledges	29,767	84,452
Net assets released from restrictions	(552,981)	(642,793)
Cumulative effect of change in accounting principle	-	3,765,129
Change in temporarily restricted net assets	(25,440)	3,326,799
Permanently Restricted Net Assets		
Net realized gains on investments	347,236	279,719
Net unrealized losses on investments	(8,714)	(474,329)
Cumulative effect of change in accounting principle	-	(1,811,787)
Change in permanently restricted net assets	338,522	(2,006,397)
Change in Net Assets	(6,329,335)	(8,269,098)
Net Assets - Beginning of Year	31,459,561	39,728,659
Net Assets - End of Year	$ 25,130,226	$ 31,459,561

The accompanying notes are an integral part of the combined financial statements

THE WESTERLY HOSPITAL AND SUBSIDIARY
(A Controlled Affiliate of Community Health of Westerly, Inc.)
COMBINED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2010 AND 2009

	2010	2009
Cash Flows from Operating Activities		
Change in net assets	$ (6,329,335)	$ (8,269,098)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	4,592,213	4,450,501
Amortization	23,490	23,489
Contributions restricted for long-term investment	(41,839)	(264,051)
Provision for uncollectible accounts	5,962,284	7,249,449
Increase in additional minimum pension liability	3,190,322	4,854,582
Net realized and unrealized (gains) losses on permanently restricted investments	(338,522)	194,610
Net unrealized gains on unrestricted investments	(443,946)	(386,985)
Investment income and unrealized gains on temporarily restricted net assets	(455,934)	(24,858)
(Increase) decrease in operating assets:		
Patient accounts receivable	(5,839,162)	(5,334,569)
Inventories	(141,993)	(62,155)
Other assets	(289,650)	109,282
Promises to give	96,604	84,446
Due from related party	249,710	(358,047)
Increase (decrease) in operating liabilities:		
Accounts payable and accrued expenses	(570,356)	974,982
Deferred revenue	1,351,056	1,898
Accrued pension cost	1,008,836	679,787
Estimated third-party payor settlements	(6,706)	(124,890)
Asset retirement obligation	23,613	35,177
Net cash provided by operating activities	2,040,685	3,833,550
Cash Flows from Investing Activities		
Purchase of property, plant and equipment	(2,796,874)	(979,002)
Sale (purchase) of investments, net	(268,162)	1,611,017
Decrease in other long-term assets, net	84,951	143,313
Net cash provided by (used in) investing activities	(2,980,085)	775,328
Cash Flows from Financing Activities		
Repayments of long-term debt	(920,738)	(867,319)
Capital lease payments, net	(811,289)	(1,010,624)
Line of credit borrowings (payments), net	2,133,503	(2,010,617)
Net cash provided by (used in) financing activities	401,476	(3,888,560)
Net Increase (Decrease) in Cash and Cash Equivalents	(537,924)	720,318
Cash and Cash Equivalents - Beginning of Year	2,951,166	2,230,848
Cash and Cash Equivalents - End of Year	$ 2,413,242	$ 2,951,166
Cash Paid During the Year for Interest	$ 1,316,834	$ 1,387,457

The accompanying notes are an integral part of the combined financial statements

NOTE 1 - ORGANIZATION

The Westerly Hospital and Subsidiary (the Hospital) is a not-for-profit acute care hospital under corporate governance of Westerly Hospital Health Care, Inc. (C.H.O.W.), a not-for-profit holding company. The Westerly Hospital Foundation (the Foundation) is a not-for-profit corporation formed to promote the charitable, educational and scientific purposes of the Hospital, under corporate governance of the Hospital. The Foundation is a subsidiary of the Hospital. Other affiliated entities under the corporate governance of C.H.O.W. include Mastuxet Realty, Inc., The Westerly Hospital Auxiliary, Inc., Women's Health of Westerly, LLC, Westerly Hospital Energy Co., LLC, Atlantic Medical Group, Inc. (formally C.H.O.W. NewCo, Inc.), North Stonington Health Center, Inc., and Eldereval, LLC.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation - The combined financial statements reflect the accounts of the Hospital and the Foundation and have been prepared on the accrual basis of accounting, in conformity with accounting principles generally accepted in the United States of America (GAAP). All significant intercompany balances and transactions have been eliminated in combination.

The Hospital reports information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets.

Unrestricted Net Assets - Unrestricted net assets represent available resources other than donor-restricted contributions. These resources may be expended at the discretion of the Board of Trustees or may otherwise be limited by contractual agreements with outside parties. The Board of Trustees has designated a portion of unrestricted net assets as described in Note 21.

Temporarily Restricted Net Assets - Temporarily restricted net assets represent contributions that are restricted by the donor as to purpose or time of expenditure and also includes accumulated investment income and gains on donor-restricted endowment assets that have not been appropriated for expenditure. Temporarily restricted net assets are available for the following:

	2010	2009
Women's Initiative Campaign	$ 11,950	$ 108,554
Charity care	9,872	8,863
Physician education	53,644	66,733
Capital expenditures	231,643	282,551
Available for appropriation by Board of Trustees	3,513,444	3,379,358
Other	6,514	6,448
	$ 3,827,067	$ 3,852,507

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Permanently Restricted Net Assets - Permanently restricted net assets represent resources that have donor-imposed restrictions that require that the principal be maintained in perpetuity but permit the Hospital to expend the income earned thereon for general operating purposes (except for the Morgan trust, which specifies that income is restricted for charity care). Such assets are included in the Hospital's endowment funds.

Funds Held in Trust by Others - The Hospital is the sole beneficiary of the income from the Louise D. Hoxsey Foundation and the Estate of Charles A. Morgan trusts, which are held in perpetuity by an independent trustee. These trusts are recorded at market value and are included in assets limited as to use and permanently restricted net assets. The income from the Hoxsey trust is unrestricted, and Morgan trust income is restricted for charity care.

Annual distributions from the trusts are reported as other revenue that increases unrestricted net assets.

Income Taxes - The Hospital and the Foundation are organizations as described in Section 501(c)(3) of the Internal Revenue Code and are generally exempt from federal income taxes on related income under the Code.

The tax returns of the Hospital and the Foundation for the years ended September 30, 2007 through 2010 are subject to examination by the Internal Revenue Service (IRS) and various state jurisdictions.

Excess of Revenues and Gains over Expenses - The combined statements of operations and changes in net assets include excess (deficiency) of revenues and gains over expenses. Changes in unrestricted net assets, which are excluded from excess (deficiency) of revenues and gains over expenses, consistent with industry practice, include unrealized gains and losses on investments, capital transactions with C.H.O.W. and affiliated entities, and changes in additional minimum pension liability).

Use of Estimates - The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant estimates include third-party payor reserves, contractual allowances on patient revenue, accrued pension costs and the reserve for uncollectible accounts. Actual results could differ from those estimates.

Change in Accounting Principle - In 2009, the Hospital was required to change its accounting for donor-restricted endowments due to the issuance of Financial Accounting Standards Board Staff Position No. 117-1, *Endowments of Not-for-Profit Organizations: Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act, and Enhanced Disclosures for All Endowment Funds (FAS 117-1)*. Previously, accumulated gains and income on donor-restricted endowment assets were classified either as unrestricted or permanently

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

restricted net assets. In accordance with GAAP, accumulated gains and income on donor-restricted endowment assets are classified as temporarily restricted net assets until appropriated for expenditure. This change in accounting principle had no effect on total net assets. The reclassification of net assets from unrestricted and permanently restricted to temporarily restricted is disclosed in Note 3 and Note 21.

Cash and Cash Equivalents - Cash and cash equivalents include investments in certain instruments with an original maturity of three months or less, excluding amounts whose use is limited by donor designation or other arrangements under trust agreements that, at times, may exceed federally insured limits. In addition, cash equivalents may, at times, be invested in instruments not covered by federal insurance. The Hospital's deposits exceeded federal depository insurance limits as of September 30, 2010 and 2009. However, the Hospital has not experienced any losses in such accounts or instruments, and management believes the Hospital is not exposed to any significant credit risk on cash and cash equivalents.

Inventories - Inventories, consisting principally of supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market.

Promises to Give - Unconditional promises to give cash and other assets to the Foundation are reported at fair value at the date the promise is received. Unconditional promises to give are reported as temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets.

Investments - Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the combined balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues and gains over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess (deficiency) of revenues and gains over expenses unless the investments are trading securities. None of the Hospital's investments are trading securities.

A decline in the market value of an investment security below its cost that is designated to be other than temporary is recognized through an impairment charge. The impairment charge is included in the excess of expenses over revenues and gains in the combined statements of operations and changes in net assets, and a new cost basis is established (see Note 9).

Investment securities are exposed to various risks, such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is possible that changes in the values of investment securities could occur in the near term and that such changes could materially affect the investment balances and activity reflected in the combined financial statements. The Hospital maintains a diversified portfolio of investments and is actively monitoring the financial markets.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Assets Limited as to Use - Assets limited as to use primarily include assets restricted by donors, assets held by trustees under indenture agreements and designated assets set aside by the Board of Trustees to function as endowment, over which the Board retains control and at its discretion may use for other purposes.

Property, Plant and Equipment - Property, plant and equipment acquisitions that individually exceed $1,500 are recorded at cost. Depreciation is provided over the estimated useful lives of the assets, 3-30 years, on a straight-line basis. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or estimated useful life of the equipment. Such amortization is included in depreciation in the combined financial statements. Maintenance and repairs are charged to expense as incurred, and renovations that extend the original expected life of the related assets are capitalized.

Gifts of long-lived assets such as land, buildings or equipment are reported as unrestricted support and are excluded from the excess of revenues and gains over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Without explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Deferred Financing Costs - Deferred financing costs are amortized over the lives of the related revenue bonds.

Net Patient Service Revenue - The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Restricted and Unrestricted Revenue and Support - Contributions received are recorded as unrestricted, temporarily restricted or permanently restricted support, depending on the existence and/or nature of any donor restrictions.

Support that is restricted by the donor is reported as an increase in unrestricted net assets if the restriction expires in the reporting period in which the support is recognized. All other donor-restricted support is reported as an increase in temporarily or permanently restricted net assets, depending on the nature of the restriction. When a restriction expires (that is, when a stipulated time restriction ends or purpose restriction is accomplished), temporarily restricted net assets are reclassified to unrestricted net assets and reported in the combined statements of operations and changes in net assets as net assets released from restrictions.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Assessments - During 2010 and 2009, the State of Rhode Island assessed a licensing fee to all Rhode Island hospitals based on each hospital's gross patient revenue. The licensing fee expense included in supplies and other expenses in the accompanying combined statements of operations and changes in net assets was $3,807,403 and $3,539,944 for 2010 and 2009, respectively.

Malpractice Insurance Coverage and Estimated Malpractice Costs - The Hospital maintains its malpractice coverage on a claims-made basis and has renewed its policy for fiscal year 2011. The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Charity Care and Provision for Bad Debts - The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage and other collection indicators.

Nonoperating Gains and Losses - The Hospital records unrestricted investment income from endowment funds and board-designated assets as nonoperating gains within the combined statements of operations and changes in net assets. All gifts and grants are considered to be available for general use, unless specifically restricted by the donor, and are recorded at fair market value at the date received.

Donated Services - A substantial number of unpaid volunteers have made significant contributions of their time to the Hospital's programs and supporting services. These contributed services are not recorded as contributions in the combined financial statements.

State Unemployment Compensation Method - The Hospital uses the self-insurance method for unemployment insurance under which the Hospital reimburses the State of Rhode Island for actual unemployment benefits paid by the State.

Asset Retirement Obligations - The Hospital has recognized a liability related to certain of the Hospital's pipe coverings and floor tiles that contain asbestos that must be removed upon demolition or upon extensive renovation. An asset retirement obligation of $1,412,870 and $1,389,257 has been included on the accompanying combined balance sheets as of September 30, 2010 and 2009, respectively. Accretion expense of $23,613 was recognized by the Hospital during 2010. The Hospital expects to, and has the ability to, continue to maintain and operate its remaining buildings without undertaking any activities that would require removal of the asbestos.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Subsequent Events - In preparing these combined financial statements, management has evaluated subsequent events through March 3, 2011, which represents the date the combined financial statements were available to be issued.

NOTE 3 - RESTATEMENT OF ENDOWMENT NET ASSETS

In 2009, the Rhode Island Prudent Management of Institutional Funds Act (RIPMIFA) became effective and applies to the Hospital.

Accordingly, the Hospital adopted the principles of FAS 117-1 effective as of the beginning of the fiscal year ended September 30, 2009. This resulted in the reclassification of accumulated unspent investment returns of $1,953,342 from unrestricted net assets to temporarily restricted net assets, as more fully described in Note 21. The adoption of RIPMIFA also resulted in a reclassification of $1,811,787 from permanently restricted net assets to temporarily restricted net assets. The amount of this reclassification represented the amount by which the permanently restricted funds were increased in order to maintain the purchasing power of the fund, as previously required by the Uniform Management of Institutional Funds Act.

These reclassifications are shown as a cumulative effect of change in accounting principle in the accompanying combined financial statements.

NOTE 4 - CHARITY CARE

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services and supplies, and equivalent service statistics.

The following information summarizes charity care provided during the years ended September 30, 2010 and 2009:

	2010	2009
Charges Foregone, Based on Established Rates	$ 2,204,887	$ 1,091,713

The Hospital also subsidizes the cost of treating patients who are on government assistance where reimbursement is below cost.

NOTE 5 - NET PATIENT SERVICE REVENUE

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare - Inpatient acute care and certain outpatient services rendered to Medicare program beneficiaries are reimbursed at prospectively determined rates. Inpatient rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Payments for outpatient services are based on ambulatory payment classifications.

The Hospital is paid for certain cost reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's classification of patients under the Medicare Prospective Payment System and the appropriateness of their admissions are subject to an independent review by a peer review organization under contract with the Medicare program. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through September 30, 2008. Management does not believe that future settlements will have a material impact on operations.

Blue Cross - The Hospital is reimbursed at prospectively determined rates for inpatient services provided to Blue Cross patients. Outpatient services are reimbursed in accordance with a negotiated fee. Both inpatient and outpatient services are reimbursed on predetermined volumes.

Medicaid - The Hospital is reimbursed for charges to Medicaid patients under the terms of a prospective rating contract. Under the contract, reimbursement rates are determined in advance based on budgeted costs and anticipated patient care statistics for the applicable year, as negotiated and agreed to by the third-party contractual agencies. Adjustments to anticipated patient care statistics are made at year end in accordance with provisions in the contract that recognize actual volume and intensity statistics. Settlements have been reached with Medicaid through September 30, 2004. Management does not believe that future settlements will have a material impact on operations.

United Health Plans of New England, Inc. - The Hospital is reimbursed for inpatient services provided to United Health patients on a negotiated per diem rate. Outpatient services are reimbursed in accordance with a predetermined fee schedule.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action. Failure to comply with such laws and regulations can result in fines, penalties and exclusion from the Medicare and Medicaid programs. The Hospital believes it is in compliance with all applicable laws and regulations.

NOTE 6 - OTHER REVENUE

Other revenue for the years ended September 30, 2010 and 2009, comprises the following:

	2010	2009
Morgan trust income	$ 301,296	$ 307,625
Cafeteria sales	199,382	177,733
Pharmacy sales	1,520	1,142
Rental income, service fees and other	1,306,989	869,797
	$ 1,809,187	$ 1,356,297

NOTE 7 - PATIENT ACCOUNTS RECEIVABLE

Accounts receivable are presented in the combined balance sheets net of an allowance for doubtful accounts of $5,146,027 and $6,635,205 at September 30, 2010 and 2009, respectively. The Hospital provided $5,962,284 and $7,249,449 for uncollectible patient accounts during the years ended September 30, 2010 and 2009, respectively. Accounts are written off when all collection efforts have been exhausted. Recoveries of approximately $1,100,000 and $1,200,000 were netted against the provision for uncollectible accounts for the years ended September 30, 2010 and 2009, respectively.

NOTE 8 - PROMISES TO GIVE

Unconditional promises to give as of September 30, 2010 and 2009, are expected to be collected as follows:

	2010	2009
Within one year	$ 11,950	$ 113,231
Within two to five years	-	7,465
Total contributions receivable	11,950	120,696
Less discounts to net present value and reserve for uncollectible pledges	-	(12,142)
Net Unconditional Promises to Give	$ 11,950	$ 108,554

The discount rate used in calculating the present value of promises to give for the years ended September 30, 2010 and 2009, was 3.4%.

Of the promises to give, $-0- and $74,000 is due from The Westerly Hospital Auxiliary, Inc., a related party, as of September 30, 2010 and 2009, respectively.

NOTE 9 - ASSETS LIMITED AS TO USE

The following information is presented as of September 30, 2010 and 2009, regarding assets whose use is restricted by donors or limited by the board:

	2010	2009
Cash and short-term investments	$ 1,925,462	$ 1,962,780
Marketable equity securities	13,635,129	10,638,635
Other investments, primarily bonds	5,366,770	7,110,573
	$ 20,927,361	$ 19,711,988

The following information is presented as of September 30, 2010 and 2009, regarding assets invested by trustee under loan agreement:

	2010	2009
Cash and short-term investments	$ 1,316,657	$ 1,277,983
Other investments, primarily bonds	646,913	618,864
	$ 1,963,570	$ 1,896,847

The following information is presented as of September 30, 2010 and 2009, regarding assets held in trust:

	2010	2009
Cash and short-term investments	$ 128,888	$ 284,721
Marketable equity securities	4,268,042	3,763,021
Other investments, primarily bonds	3,159,621	3,242,502
	$ 7,556,551	$ 7,290,244

Included in interest and investment income is an investment impairment charge totaling $10,608 and $461,557 for the years ended September 30, 2010 and 2009, respectively, to reflect other than temporary declines in the fair market value of certain equity securities.

Investment income is stated net of management fees and expenses, which were $72,241 and $69,626 for the years ended September 30, 2010 and 2009, respectively.

At September 30, 2010, investments with market value below cost for 12 months or more included certain equity and bond securities with market values of $3,680,683 and $10,194, respectively, and unrealized losses of $1,540,842 and $160, respectively. Investments with market value below cost for less than 12 months at September 30, 2010 included certain equity and bond securities with a market value of $3,408,104 and $175,593, respectively, and an unrealized loss of $425,272 and $4,811, respectively.

NOTE 10 - PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment at September 30, 2010 and 2009, comprises the following:

	2010	2009
Land and land improvements	$ 2,450,129	$ 2,428,957
Building and building improvements	43,905,405	43,510,583
Equipment	63,691,732	63,178,602
Construction in progress	1,965,142	122,865
	112,012,408	109,241,007
Less accumulated depreciation and amortization	75,511,393	70,944,653
Net Property and Equipment	$ 36,501,015	$ 38,296,354

NOTE 11 - LONG-TERM DEBT AND FUNDS INVESTED BY TRUSTEE

The Hospital has a 6.25% secured promissory note payable in monthly installments of $40,493 until June 15, 2014. After June 15, 2014, the interest rate will be adjusted to either 150 basis points greater than the bank's five- or ten-year cost of funds or the then 30-day LIBOR rate. It is the Hospital's option which rate to choose. The final payment is due June 15, 2024.

In January 1994, the Rhode Island Health and Educational Building Corporation issued $20,485,000 of Hospital Financing Revenue Bonds - The Westerly Hospital Issue - Series 1994 (the Bonds) on behalf of the Hospital pursuant to the Loan and Trust Agreement dated January 15, 1994 (the Bond Agreement). The terms of the Bond Agreement stipulate that interest will be paid at rates between 2.75% and 6% per annum, with semiannual principal installment payments commencing July 1, 1994 and through July 1, 2019.

The terms of the Bond Agreement require that the Hospital make quarterly deposits to the trustee that are sufficient to provide for the payment of principal and interest due on the bonds. Such deposits are included in assets limited as to use. The Bond Agreement also requires the Hospital to maintain a certain debt coverage ratio.

NOTE 11 - LONG-TERM DEBT AND FUNDS INVESTED BY TRUSTEE (Continued)

Long-term debt is comprised of the following at September 30, 2010 and 2009:

	2010	2009
6.25% secured promissory note, principal maturing June 15, 2024, monthly installments are $40,493, interest is 6.25% until June 15, 2014	$ 4,451,767	$ 4,648,709
Series 1994 Tax-Exempt Revenue Bonds, principal maturing in varying annual amounts, due July 1, 2019, collateralized by a lien on certain equipment	8,610,000	9,315,000
7.72% mortgage loan, payable in monthly installments of $6,274, including interest, collateralized by a mortgage on certain property	711,430	730,226
	13,773,197	14,693,935
Less current installments	984,831	925,659
Total Long-Term Debt	$ 12,788,366	$ 13,768,276

The aggregate maturities of long-term debt for the next five years and thereafter are as follows:

Year Ending September 30	
2011	$ 984,831
2012	1,045,266
2013	1,106,721
2014	1,174,262
2015	1,247,963
Thereafter	8,214,154
	$ 13,773,197

The Hospital has a $3,500,000 secured line-of-credit agreement with a bank as of September 30, 2010 and 2009. The Hospital had outstanding borrowings of $3,066,767 and $2,433,264 against the line of credit as of September 30, 2010 and 2009, respectively. This amount is included within lines of credit on the accompanying combined balance sheets. Interest is payable on the outstanding balance at 150 basis points in excess of the 30-day LIBOR rate. Interest was 1.75% and 1.70% at September 30, 2010 and 2009, respectively. This line-of-credit agreement expires on June 1, 2012.

NOTE 11 - LONG-TERM DEBT AND FUNDS INVESTED BY TRUSTEE (Continued)

The Hospital has a $1,500,000 secured line-of-credit agreement with a bank as of September 30, 2010 and 2009. The Hospital had outstanding borrowings of $1,500,000 and $-0- against the line of credit as of September 30, 2010 and 2009, respectively. This amount is included within lines of credit in the accompanying combined balance sheets. Interest is payable on the outstanding balance at 150 basis points in excess of the 30-day LIBOR rate. Interest was 1.75% and 1.70% at September 30, 2010 and 2009, respectively. This line of credit expires March 1, 2012.

Approximately $11,400,000 in investments and cash collateralizes the promissory note and the two lines of credit.

Under Loan Agreement, Funds Invested by Trustee - Funds invested by trustee consisted of the following accounts at September 30, 2010 and 2009, which were established in connection with the long-term debt discussed above:

	2010	2009
Debt service reserve fund	$ 1,621,542	$ 1,555,496
Principal and interest funds	339,470	338,795
Other	2,558	2,556
Total Funds Invested by Trustee	$ 1,963,570	$ 1,896,847

The principal and interest funds are used to make semiannual principal and interest payments. The debt service reserve fund represents additional funds that the Hospital is required to set aside under the Bond Agreement.

NOTE 12 - LEASES - CAPITAL

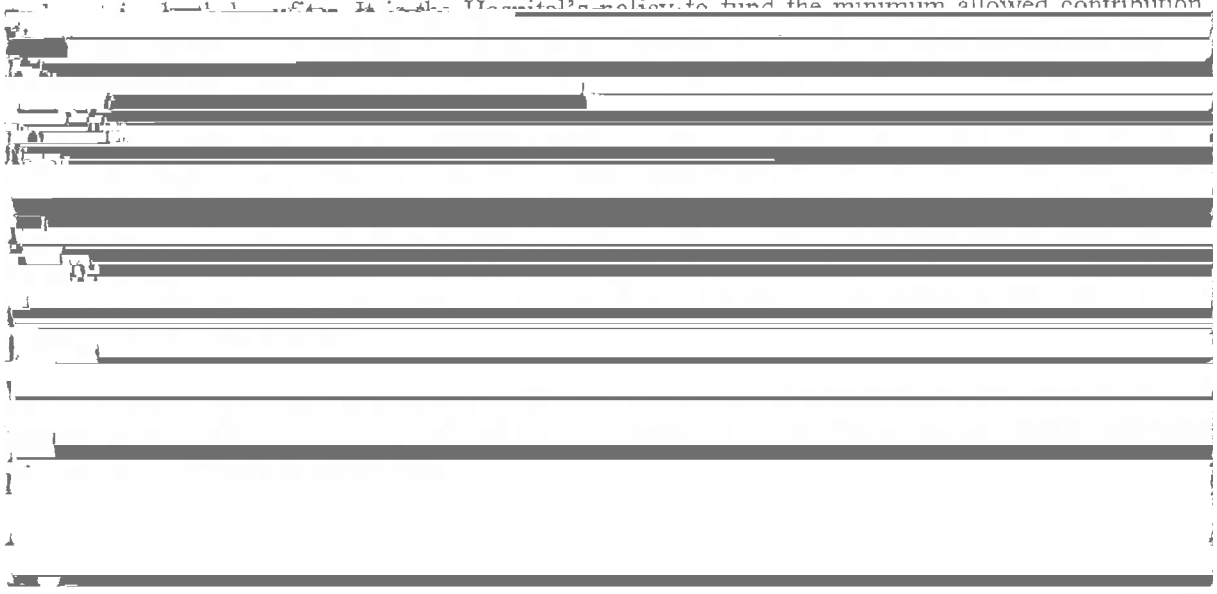
The Hospital leases various equipment under capital leases. The present value of future minimum capital lease payments is as follows:

Year Ending September 30	
2011	$ 2,551,443
2012	788,480
2013	565,169
2014	120,259
Total minimum lease payments	4,025,351
Less amount representing interest at interest rates ranging from 1.30% to 7.94%	(292,089)
Present value of net minimum capital lease payments	3,733,262
Less current portion of capital lease obligations	(2,326,753)
Long-Term Capital Lease Obligations	$ 1,406,509

The net book value of equipment under capital lease obligations is $6,808,294.

NOTE 13 - PENSION PLAN

The Hospital sponsors a noncontributory defined benefit retirement plan covering substantially all employees called The Westerly Hospital Retirement Plan (the Plan). The Plan provides pension benefits, which are based on years of service and compensation throughout the term of employment,



NOTE 13 - PENSION PLAN (Continued)

The following table sets forth the Plan's funded status and amounts recognized in the Hospital's combined financial statements at September 30, 2010 and 2009:

	2010	2009
Change in benefit obligation:		
Projected benefit obligation at beginning of year	$ 46,630,499	$ 40,592,391
Service cost	1,722,030	1,507,179
Interest cost	2,790,199	2,609,371
Benefits paid	(1,478,491)	(1,387,741)
Actuarial loss	4,339,731	3,309,299
Projected Benefit Obligation at End of Year	54,003,968	46,630,499
Change in plan assets:		
Fair value of plan assets at beginning of year	30,373,337	29,869,598
Actual return on plan assets	2,713,514	396,977
Contributions and transfers	1,939,288	1,494,503
Benefits paid	(1,478,491)	(1,387,741)
Fair Value of Plan Assets at End of Year	33,547,648	30,373,337
Accrued Pension Cost	$ 20,456,320	$ 16,257,162

The following table sets forth the unrecognized items impacting the Plan:

	2010	2009
Unrecognized loss from past experience different from that assumed and effects of changes in assumptions	$ 20,695,927	$ 17,461,924

The accumulated benefit obligation at the end of 2010 and 2009 was $48,350,539 and $41,583,268, respectively. The measurement dates are September 30, 2010 and 2009.

The following weighted average assumptions were used to determine end of year benefit obligations:

	2010	2009
Discount rate	5.50%	6.00%
Rate of compensation increase	3.00	3.00

NOTE 13 - PENSION PLAN (Continued)

Net periodic pension cost for 2010 and 2009 included the following components:

	2010	2009
Service cost - benefits earned during the period	$ 1,722,030	$ 1,507,179
Interest cost on projected benefit obligation	2,790,199	2,609,371
Expected return on assets	(2,578,906)	(2,472,901)
Recognized net actuarial loss	971,120	530,641
Net Periodic Pension Cost	$ 2,904,443	$ 2,174,290

The following weighted average assumptions were used to determine net periodic pension cost:

	2010	2009
Discount rate	6.00%	6.75%
Expected return on plan assets	8.50	8.50
Rate of compensation increase	3.00	4.50

The Hospital expects to contribute approximately $3,700,000 to the Plan during the upcoming year.

Expected benefit payments:

2011	$ 1,731,574
2012	1,862,730
2013	2,121,255
2014	2,373,581
2015	2,472,505
2016-2020	16,144,488

The asset allocation for the Plan at the end of 2010 and 2009, and the target allocation for 2010 by asset category, are as follows:

Asset Category	Target Allocations 2010	Percentage of Plan Assets at September 30 2010	2009
Equity	50%	54%	52%
Fixed income	40	42	40
Cash equivalents	10	4	8

NOTE 13 - PENSION PLAN (Continued)

The Plan's investment policy includes a mandate to diversify assets and invest in a variety of asset classes to achieve a goal of three-year average of 10%. The Plan's assets are currently invested in a variety of funds representing most standard equity and debt security classes. While no significant changes in the asset allocation are expected during the upcoming year, the Hospital may make changes at any time.

GAAP has established a fair value hierarchy that prioritizes the inputs to valuation techniques to measure fair value. Highest rank is given to unadjusted quoted prices in active markets for identical assets (Level 1) and lowest rank to unobservable inputs (Level 3). Investments are ranked based on the lowest level of input that is significant to their fair value measurement.

The fair values of all Plan assets of the Hospital are determined using quoted prices in active markets for identical assets (Level 1, as defined in the fair value hierarchy established by GAAP - see Note 20).

The fair values of the Hospital's pension plan assets at September 30, 2010 by asset class are as follows:

Asset classes:	
Equity investments - common stock	$ 17,914,711
Fixed income	13,913,697
Cash and cash equivalents	1,547,224
Convertible securities and other	172,016
Total Pension Plan Assets	$ 33,547,648

The Hospital also provides an employer funded annuity plan covering substantially all employees. Hospital contributions to the annuity plan totaled $189,178 and $256,366 during 2010 and 2009, respectively.

NOTE 14 - COMMITMENTS AND CONTINGENCIES

The Hospital is presently a defendant in several pending medical malpractice and other suits. All of these suits are being defended by counsel of the Hospital's insurance carriers. In the opinion of the Hospital's management, any settlements or judgments of these suits will be covered by insurance and will have no significant adverse effect on the financial position or results of operations of the Hospital.

NOTE 14 - COMMITMENTS AND CONTINGENCIES (Continued)

The Hospital has made a $3,500,000 line of credit available to Atlantic Medical Group, an affiliated organization under common management and control. The line of credit expires on June 30, 2013. Outstanding balances on the line of credit bear interest at Prime minus 1%. There were no balances outstanding as of September 30, 2010.

The Hospital has also guaranteed a building and equipment lease entered into by North Stonington Health Center, Inc., an affiliated organization under common management and control. The lease has a 25- year term and provides for annual base rental payments of $686,400 for the building and equipment, plus reimbursement of certain operating expenses of approximately $180,000 per year. The equipment portion of the lease provided for the purchase of equipment valued at approximately $730,000, and is amortized over a 10-year period, at which time the base rental payments will be reduced accordingly.

NOTE 15 - OPERATING LEASES

Rental expense under all significant operating leases was $735,153 and $750,502 for the years ended September 30, 2010 and 2009, respectively. At September 30, 2010, future minimum lease payments under noncancelable operating leases are as follows:

Year Ending September 30	
2011	$ 380,544
2012	235,000
2013	235,000
2014	235,000
	$ 1,085,544

NOTE 16 - DISPROPORTIONATE SHARE

The Federal government has long recognized the financial burdens that are borne by hospitals that serve an unusually large number or "disproportionate share" of low-income patients. The Hospital received disproportionate share payments of $3,008,630 and $3,556,998 for the years ended September 30, 2010 and 2009, respectively. These amounts are included in net patient revenue on the accompanying combined statements of operations and changes in net assets.

NOTE 17 - CONCENTRATION OF CREDIT RISK

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Revenues from patients and third-party payors were as follows:

	2010	2009
Medicare	37%	39%
Medicaid	2	2
Blue Cross	23	23
Other third-party payors	34	33
Patients	4	3
	100%	100%

NOTE 18 - RELATED PARTIES

The following amounts were due to the Hospital from related parties at September 30, 2010:

C.H.O.W.	$ 52,357
Women's Health of Westerly, LLC	102,152
Atlantic Medical Group, Inc.	350,000
North Stonington Health Center, Inc.	365,080
	$ 869,589

During 2010, the Hospital incurred $4,915,318 in capital transactions with affiliates, which is reflected on the accompanying combined statement of operations and changes in net assets. These capital transactions occurred with the following affiliates:

Atlantic Medical Group, Inc.	$ 3,676,242
Women's Health of Westerly, LLC	1,228,076
Eldereval, LLC	11,000
	$ 4,915,318

NOTE 19 - FUNCTIONAL EXPENSES

The Hospital provides general healthcare services to residents within its geographic location. Expenses related to providing these services are as follows:

	2010	2009
Healthcare services	$ 60,038,899	$ 56,466,938
Provision for uncollectible accounts	5,962,284	7,249,449
General and administrative	21,171,095	20,481,617
Interest	1,306,259	1,377,482
Depreciation and amortization	4,592,213	4,450,501
	$ 93,070,750	$ 90,025,987

NOTE 20 - FAIR VALUE OF FINANCIAL INSTRUMENTS

GAAP has established a fair value hierarchy that prioritizes the inputs to valuation techniques to measure fair value. Highest rank is given to unadjusted quoted prices in active markets for identical assets (Level 1) and lowest rank to unobservable inputs (Level 3). Investments are ranked based on the lowest level of input that is significant to their fair value measurement. The three levels of the fair value hierarchy are described below:

Level 1 - Quoted market prices (unadjusted) in active markets for identical assets or liabilities to which the Hospital has the ability to access at the measurement date.

Level 2 - Inputs and information other than quoted market indices included in Level 1 that are observable for the asset or liability, either directly or indirectly, and the Hospital has the ability to redeem the asset or liability in the near term subsequent to the measurement date.

Level 3 - Unobservable inputs are used to measure the fair value to the extent that observable inputs are not available, and the Hospital does not have the ability to redeem the asset or liability in the near term subsequent to the measurement date.

The following methods and assumptions were used to estimate the fair value of each class of financial instruments for which it is practicable to estimate that value.

Cash and Cash Equivalents - The carrying amount approximates fair value because of the short maturity of these instruments.

Investments - The fair value of certain investments is estimated based on quoted market prices or estimates of fair value for those or similar investments.

NOTE 20 - FAIR VALUE OF FINANCIAL INSTRUMENTS (Continued)

Bonds and Notes Payable - The estimated fair market value of the Hospital's long-term debt at September 30, 2010 is approximately $13,825,000, estimated using discounted cash flow analysis, based on current incremental borrowing rates for similar types of borrowing arrangements.

Assets Measured at Fair Value on a Recurring Basis - The following is a summary of the source of fair value measurements for assets that are measured at fair value on a recurring basis as of September 30, 2010:

Description	September 30, 2010	Fair Value Measurements Using Level 1	Level 2	Level 3
Cash and cash equivalents	$ 2,413,242	$ 2,413,242	$ -	$ -
Assets whose use is restricted by donors or limited by the Board	20,927,361	20,927,361	-	-
Promises to give, net	11,950	-	-	11,950
Under loan agreement, funds invested by trustee	1,963,570	1,963,570	-	-
Funds held in trust	7,556,551	-	-	7,556,551
Total	$ 32,872,674	$ 25,304,173	$ -	$ 7,568,501

Assets Measured at Fair Value on a Recurring Basis Using Significant Unobservable Inputs (Level 3) - The following is a summary of the changes in the balances of investments and promises to give measured at fair value on a recurring basis using significant unobservable inputs:

	Funds Held in Trust	Promises to Give, Net
Balance - beginning of year	$ 7,290,244	108,554
Net realized gains	280,625	-
Net unrealized losses	(14,318)	-
Collections	-	(96,604)
Balance - End of Year	$ 7,556,551	11,950

Funds held in trust represent the right to receive a future stream of payments from the trust. The underlying assets in the trust would be classified as Level 1 if the Hospital held them directly.

NOTE 21 - ENDOWMENT

The Hospital's endowment consists of approximately 10 individual funds established for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. As required by GAAP, net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law - The Hospital has interpreted RIPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by RIPMIFA. In accordance with RIPMIFA, the Hospital considers the following factors in making a determination to appropriate from accumulated donor-restricted endowment funds:

- The duration and preservation of the fund
- The purposes of the Hospital and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the Hospital
- The investment policies of the Hospital
- The expected tax consequences, if any, of investment decisions or strategies
- The role that each investment or course of action plays within the overall investment portfolio of the fund
- The needs of the Hospital and the fund to make distributions to preserve capital
- An asset's special relationship or special value, if any, to the charitable purposes of the Hospital

NOTE 21 - ENDOWMENT (Continued)

Endowment net asset composition by type of fund is as follows as of September 30, 2010:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 3,513,444	$ 4,744,092	$ 8,257,536
Board-designated endowment funds	12,368,211	-	-	12,368,211
Total	$ 12,368,211	$ 3,513,444	$ 4,744,092	$ 20,625,747

Changes in endowment net assets are as follows for the year ended September 30, 2010:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets - beginning of year	$ 11,296,158	$ 3,379,358	$ 4,671,877	$ 19,347,393
Investment return:				
Investment income	307,274	109,469	66,612	483,355
Unrealized investment gain	443,946	345,450	5,603	794,999
Total investment return	751,220	454,919	72,215	1,278,354
Appropriation of endowment assets for expenditure/transfer	320,833	(320,833)	-	-
Endowment Net Assets - End of Year	$ 12,368,211	$ 3,513,444	$ 4,744,092	$ 20,625,747

NOTE 21 - ENDOWMENT (Continued)

Endowment net asset composition by type of fund is as follows as of September 30, 2009:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 3,379,358	$ 4,671,877	$ 8,051,235
Board-designated endowment funds	11,296,158	-	-	11,296,158
Total	$ 11,296,158	$ 3,379,358	$ 4,671,877	$ 19,347,393

Changes in endowment net assets are as follows for the year ended September 30, 2009:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets - beginning of year	$ 13,831,134	$ -	$ 6,430,642	$ 20,261,776
Net asset reclassifications based on change in law	(1,953,342)	3,765,129	(1,811,787)	-
	11,877,792	3,765,129	4,618,855	20,261,776
Investment return:				
Investment income	272,570	192,049	69,685	534,304
Unrealized investment loss	(354,204)	(168,208)	(16,663)	(539,075)
Total investment return	(81,634)	23,841	53,022	(4,771)
Appropriation of endowment assets for expenditure	(500,000)	(409,612)	-	(909,612)
Endowment Net Assets - End of Year	$ 11,296,158	$ 3,379,358	$ 4,671,877	$ 19,347,393

Funds with Deficiencies - From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or RIPMIFA requires the Hospital to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature that are reported in unrestricted net assets were approximately $81,100 and $104,500 as of September 30, 2010 and 2009, respectively. These deficiencies resulted from unfavorable market fluctuations and continued appropriation for certain programs that was deemed prudent by the Board of Trustees.

NOTE 21 - ENDOWMENT (Continued)

Return Objectives and Risk Parameters - The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period(s), as well as board-designated funds. Under this policy, as approved by the Board of Trustees, fund managers are expected to produce a total return exceeding the median of a universe of managers with similar asset allocation objectives. On an annualized, net-of-fees basis, the total return of the portfolio will be expected to equal or exceed inflation plus 3% over a rolling three-year period. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives - The fund shall be allocated across a number of investment classes to provide diversification and achieve the fund's investment objectives. The following table defines the fund's target asset allocation and range for each asset class:

Asset Class	Min Wt.	Target Wt.	Max Wt.	Representative Index
Equities	40%	50%	65%	70% Standard & Poor's 500 15% Russell 2000 Value 15% Europe Australia Far East
Fixed income	25%	40%	60%	100% Lehman Bros Govt./Corp
Cash and equivalents	0%	10%	20%	100% Salomon 30-day US T-bills

This asset allocation plan provides for diversification of assets in an effort to maximize the investment return and manage the risk of the fund consistent with market conditions. Due to the fluctuation of market values, allocations within a specified range constitute compliance within the policy. An extended period of time may be required to fully implement the asset allocation plan, and periodic revisions will be required.

Spending Policy and How the Investment Objectives Relate to Spending Policy - Distributions from the endowment are specifically approved by the Board of Trustees as deemed fit to meet the operating and capital needs of the Hospital. In implementing this spending policy, and subject to the intent of a donor expressed in a gift instrument, the Hospital may appropriate for expenditure or accumulate so much of its fund as it determines to be prudent for the uses, benefits, purposes and duration for which its fund is established. In making a determination to appropriate or accumulate, the Hospital shall act in good faith, with the care that an ordinarily prudent person in a like position would exercise under similar circumstances.

NOTE 21 - ENDOWMENT (Continued)

The investment program shall invest according to an asset allocation plan that is designed to meet the goals of the Fund. The plan will be based on a number of factors, including:

- The projected spending needs;
- The maintenance of sufficient liquidity to meet spending payments; and
- The return objectives and risk tolerances of the fund as defined in the Investment Philosophy

The Westerly Hospital
CONSOLIDATED BALANCE SHEET
As of September 30, 2011

	Current 30-Sep-11	Prior Month	30-Sep-10	$ Change Cur-Prior	$ Change Cur-10
Current Assets					
Cash and Cash Equivalents	$3,212	$448	$2,413	$2,764	$799
Receivables:					
Patient accounts	33,691	31,977	26,887	1,714	6,804
Less allowances	(24,687)	(23,132)	(19,551)	(1,555)	(5,136)
Net Patient Receivables	9,004	8,845	7,336	159	1,668
Inventories	1,557	1,594	1,612	(37)	(55)
Prepaid exps and other current assets	1,395	283	1,167	1,112	228
Total Current Assets	15,168	11,169	12,528	3,999	2,640
Board Designated Restr Assets					
By Board to Function as Endowment	7,440	8,026	12,368	(587)	(4,928)
Promises to Give	0	0	12	0	(12)
Under Loan Agreement, Funds Invested	2,010	1,689	1,964	321	46
Accumulated Earnings on Permanent Endowment	2,275	2,444	3,513	(170)	(1,238)
By Donors for Specific Purpose	119	119	302	0	(183)
By Donor for Permanent Endowment	4,827	4,852	4,743	(25)	84
Held In Trust	3,875	8,155	7,557	(4,280)	(3,682)
Total Restricted Assets	20,545	25,286	30,459	(4,740)	(9,914)
Property and Equipment					
Property Plant and Equipment	116,567	115,986	111,933	581	4,634
Less accumulated depreciation	(80,206)	(79,723)	(75,432)	(483)	(4,774)
Subtotal	36,361	36,263	36,501	98	(140)
Other Assets					
Due from Related Parties	4,162	3,635	870	527	3,292
Other Long-term Assets	513	513	513	(0)	0
Deferred Financing Cost, Net	186	188	210	(2)	(24)
TOTAL ASSETS	$76,937	$77,055	$81,081	($118)	(4,144)

The Westerly Hospital
CONSOLIDATED BALANCE SHEET
As of September 30, 2011

	Current 30-Sep-11	Prior Month	30-Sep-10	$ Change Cur-Prior	$ Change Cur-10
LIABILITIES AND NET ASSETS					
Current Liabilities					
Line of Credit	$ 4,967	$ 4,967	$ 4,567	$0	$400
Current portion - long-term debt	3,452	3,452	3,312	0	140
Accounts payable/Accrued Exp/Other	14,730	10,339	7,209	4,391	7,521
Accrued Payroll	3,947	4,491	3,927	(544)	20
Third party payable	725	805	872	(80)	(147)
Total Current Liabilities	27,821	24,055	19,887	3,766	7,934
Long-term debt, net	12,374	13,607	14,195	(1,233)	(1,821)
Asset Retirement Obligation	1,413	1,413	1,413	0	(0)
Additional Pension Liability	26,311	20,449	20,456	5,862	5,855
TOTAL LIABILITIES	67,919	59,523	55,951	8,396	11,968
Net Assets					
Unrestricted	(2,077)	1,961	9,002	(4,039)	(11,079)
Temporarily restricted	2,393	2,563	3,827	(170)	(1,434)
Permanently restricted	8,702	13,007	12,301	(4,305)	(3,599)
Total Net Assets	9,018	17,531	25,130	(8,514)	(16,112)
TOTAL LIABILITIES AND NET ASSETS	$ 76,937	$ 77,055	$ 81,081	$ (118)	(4,144)

The Westerly Hospital
CONSOLIDATED STATEMENT OF OPERATIONS
For the Period Ending September 2011

	Month					Year-to-Date				
	Actual	Budget	$ Change	% Change	FY 2010	Actual	Budget	$ Change	% Change	FY 2010
UNRESTRICTED REVENUES:										
Inpatient acute	$ 6,915	$ 6,836	$ 79	1 16	$ 6,044	$ 70,375	$ 80,119	$ (9,744)	(12 16)	$ 73,656
Outpatient acute	12,846	13,331	(485)	(3.64)	12,244	149,838	157,497	(7,660)	(4 86)	145,398
GROSS PATIENT REVENUES	19,761	20,167	(406)	(2 01)	18,288	220,213	237,616	(17,403)	(7.32)	219,054
DEDUCTIONS FROM REVENUE										
Contractual Allowance	12,269	12,225	44	0 36	10,730	134,601	144,035	(9,433)	(6 55)	130,506
Disproportionate Share	69	63	6	-	(41)	619	750	(131)	-	(210)
Uncompensated Care	198	176	21	12.14	221	1,689	2,078	(389)	(18.70)	2,213
TOTAL DEDUCTIONS FROM REVENUE	12,536	12,464	72	0 58	10,910	136,910	146,863	(9,953)	(6 78)	132,509
NET PATIENT REVENUES	7,226	7,704	(478)	(6.20)	7,378	83,304	90,754	(7,450)	(8.21)	86,545
TOTAL OTHER OPERATING REVENUE	3,635	241	3,395	1,409 52	157	5,317	2,516	2,801	111 30	1,917
TOTAL NET OPRATING REVENUE	10,861	7,945	2,917	36.71	7,535	88,620	93,270	(4,650)	(4 99)	88,462
OPERATING EXPENSES:										
Salaries & Wages	2,623	3,227	604	18 72	3,274	37,468	39,174	1,706	4 36	38,752
Vacation and sick Accrual	(19)	(3)	16	(627 42)	1	342	331	(11)	(3.33)	385
Temporary Help	59	21	(38)	(181 04)	39	376	250	(126)	(50 30)	278
Total Salaries	2,664	3,246	582	17.94	3,314	38,185	39,755	1,570	3 95	39,415
Employee benefits	1,515	1,159	(356)	(30.75)	992	14,245	13,457	(788)	(5 86)	12,192
Workers Compensation	20	31	11	35 94	28	230	367	137	37 31	311
Professional Fees	300	140	(161)	(114 90)	171	1,923	1,709	(214)	(12 55)	2,050
Med/Surg Supplies	573	491	(82)	(16 70)	331	5,693	5,886	192	3 27	5,700
Drugs	288	243	(44)	(18 15)	452	2,653	2,919	266	9 12	3,203
Other Supplies	198	165	(33)	(20 12)	191	2,061	1,965	(96)	(4 89)	1,918
Utilities	120	132	12	9 11	146	1,562	1,559	(2)	(0 15)	1,421
Purchased Services	743	780	37	4 76	653	9,951	9,999	48	0 48	7,928
Insurance	165	113	(51)	(45.42)	135	1,292	1,358	65	4 82	1,219
Other Expenses	146	89	(57)	(64.58)	164	1,073	1,076	3	0 31	1,311
Bad Debts	657	578	(79)	(13 65)	394	6,782	6,810	28	0 41	5,962
Leases and Rentals	(66)	58	124	213 00	42	606	698	92	13 22	735
Depreciation	482	383	(99)	(25 78)	407	4,699	4,600	(99)	(2 15)	4,591
Interest	153	119	(35)	(29 27)	108	1,411	1,422	12	0 83	1,306
TOTAL OPERATING EXPENSES	7,957	7,726	(231)	(2.99)	7,528	92,367	93,581	1,214	1 30	89,262
OPERATIONS INCOME BEFORE RESTRUCTURE	2,904	219	2,686	(1,228.29)	7	(5,746)	(311)	(5,436)	(1,106.41)	(800)
RESTRUCTURE COSTS	-	-	-			1,460		(1,460)		
OPERATIONS INCOME	2,904	219	2,686	(1,228.29)	7	(5,206)	(311)	(4,896)	(1,576.57)	(800)
NON-OPERATING REVENUE AND EXPENSES:										
Interest Income/ Realized Gain on Sale of Stock	160	-	160	-	98	1,154	-	1,154	-	439
Realized Gain on Sale of Stock	-	-	-	-	-	-	-	-	-	-
Contributions	109	83	26	30 84	123	2,142	1,000	1,142	114 18	392
Other than Temporary Loss	267	-	267	-	-	267	-	267	-	-
NON-OPERATING REVENUE AND EXPENSES	536	83	453	543 02	221	3,563	1,000	2,563	256 29	831
EXCESS OF REV AND GAINS OVER EXPENSES	3,440	302	3,138	1,039.19	228	(1,643)	689	(2,333)	(338.37)	31
Loss on Impairment of Assets	-	-	-	-	-	-	-	-	-	-
Net Assets Released from Restrictions	146	-	146	-	621	1,646	-	1,646	-	1,041
Transfers to Parent Corp	(836)	(204)	(632)	-	(107)	(4,957)	(2,655)	(2,302)	-	(4,915)
Appr Value of Hoxsey and Lefferts	-	-	-	-	-	-	-	-	-	-
Unrealized Gain/Loss Investments	(545)	-	(545)	-	732	(93)	-	(93)	-	401
Minimum Pension Liab Adj	(6,244)	-	(6,244)	-	(3,183)	(6,244)	-	(6,244)	-	(3,183)
INC/DEC UNREST. NET ASSETS	$ (4,039)	$ 98	$ (4,137)	4,221.42	$ (1,709)	$ (11,291)	$ (1,966)	$ (9,326)	(474.46)	$ (6,625)

The Westerly Hospital
CONSOLIDATED BALANCE SHEET
As of April 30, 2012

	Current 30-Apr-12	Prior Month	30-Sep-11	$ Change Cur-Prior	$ Change Cur-11
Current Assets					
Cash and Cash Equivalents	$5,830	$4,736	$3,212	$1,094	$2,618
Receivables:					
Patient accounts	29,454	30,820	33,691	(1,366)	(4,237)
Less allowances	(23,673)	(24,833)	(24,687)	1,160	1,014
Net Patient Receivables	5,781	5,987	9,004	(206)	(3,223)
Inventories	1,678	1,638	1,557	40	121
Prepaid exps and other current assets	1,233	1,860	1,395	(628)	(163)
Total Current Assets	14,522	14,222	15,168	301	(646)
Board Designated Restr Assets					
By Board to Function as Endowment	1,637	1,637	7,440	(0)	(5,803)
Promises to Give	0	0	0	0	0
Under Loan Agreement, Funds Invested	1,788	1,776	2,010	12	(222)
Accumulated Earnings on Permanent Endowment	555	1,068	2,275	(513)	(1,720)
By Donors for Specific Purpose	124	124	119	0	5
By Donor for Permanent Endowment	4,963	4,966	4,827	(3)	136
Held In Trust	4,212	4,211	3,875	2	338
Total Restricted Assets	13,280	13,782	20,545	(503)	(7,266)
Property and Equipment					
Property Plant and Equipment	116,853	116,681	116,567	172	286
Less accumulated depreciation	(83,021)	(82,618)	(80,206)	(403)	(2,815)
Subtotal	33,832	34,063	36,361	(231)	(2,529)
Other Assets					
Due from Related Parties	5,572	5,642	4,162	(70)	1,410
Other Long-term Assets	513	513	513	0	0
Deferred Financing Cost, Net	173	175	186	(2)	(14)
TOTAL ASSETS	$67,892	$68,397	$76,937	($505)	(9,045)

The Westerly Hospital
CONSOLIDATED BALANCE SHEET
As of April 30, 2012

	Current 30-Apr-12	Prior Month	30-Sep-11	$ Change Cur-Prior	$ Change Cur-11
LIABILITIES AND NET ASSETS					
Current Liabilities					
Line of Credit	$ 4,042	$ 4,042	$ 4,967	$0	($925)
Current portion - long-term debt	2,592	2,592	3,452	0	(860)
Accounts payable/Accrued Exp/Other	18,660	18,822	14,730	(162)	3,930
Accrued Payroll	3,970	3,868	3,947	103	23
Third party payable	673	681	725	(8)	(52)
Total Current Liabilities	29,937	30,004	27,821	(67)	2,116
Long-term debt, net	8,411	8,323	12,374	88	(3,963)
Asset Retirement Obligation	1,426	1,426	1,413	0	13
Additional Pension Liability	26,311	26,311	26,311	0	0
TOTAL LIABILITIES	66,084	66,064	67,919	20	(1,835)
Net Assets					
Unrestricted	(10,272)	(9,773)	(2,077)	(500)	(8,195)
Temporarily restricted	2,905	2,929	2,393	(24)	512
Permanently restricted	9,175	9,176	8,702	(1)	473
Total Net Assets	1,808	2,332	9,018	(525)	(7,210)
TOTAL LIABILITIES AND NET ASSETS	$ 67,892	$ 68,397	$ 76,937	$ (504)	(9,045)

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Balance Sheet
As of May 31, 2012

	May 31, 2012							
	The Weserly Hospital Foundation		North Stonington	WHOW	AMG	OM	Consolidating	Total
ASSETS								
Current Assets								
Checking/Savings								
Washington Trust Checking	1,446,271	588,400	26,612	(1,356)	166,652	4,721		2,231,300
Washington Trust Money Market	61,982		324	1,283	2,440			66,030
Washington Trust Special Master	3,839,336							3,839,336
LEFFERTS TEMP ,								-
INV WASH TR 94,								-
DEBT SVC RESERV,								-
CAPITAL GIFTS,								-
PEDIATRIC MM II,								-
PEDI MM III,								-
Workers Comp								-
Petty Cash	2,290		150	100	1,090			3,630
Total Checking/Savings	5,349,879	588,400	27,087	27	170,183	4,721	-	6,140,296
Accounts Receivable								
Accounts Receivable (net of B/C Advance)	29,821,399		1,926,503	540,421	1,352,432	-		33,640,754
Allowance for Third Party and Bad Debt	(24,189,378)		(1,031,042)	(342,431)	(853,742)			(26,416,594)
Other Receivable			5,601		34			5,635
Leases Receivable								-
Leases Receivable - Affiliates					-			-
Leases Receivable - Other								-
Total Accounts Receivable	5,632,021	-	901,062	197,989	498,723	-	-	7,229,795
Inventory	1,670,815							1,670,815
Prepaid Expenses					12,082			12,082
Other Current Assets								
Due From AMG								-
Due From NSHC						61,721		61,721
Due from Women's Health	102,152					65,254	(167,406)	0
Due from Sport Performance West			12,543					12,543
TRAllowance for Third Party								-
Accrued Receivables	1,802,464				-		(1,038,185)	764,279
Total Other Current Assets	1,904,616	-	12,543	-	-	126,975	(1,205,591)	838,543
Total Current Assets	14,557,331	588,400	940,691	198,016	680,989	131,696	(1,205,591)	15,891,532
Restricted Assets								
By Board to Function as Endowment	1,289,706	347,398						1,637,104
Under Loan Agreement, Funds Invested	1,796,234							1,796,234
Accumulated Earnings on Permanent Endowment	436,868							436,868
By Donors for Specific Purpose	60,287	54,750						115,037
By Donor for Permanent Endowment	4,917,313							4,917,313
Held In Trust	3,999,149							3,999,149
Total Restricted Assets	12,499,557	402,148	-	-	-	-	-	12,901,705
Fixed Assets								
Property, Plant, & Equipment	116,863,267							116,863,267
Capital Improvement			104,121		211,091			315,212
Furniture and Equipment			157,620	86,991	97,635			342,245
IT Equipment			58,973		93,132			152,105
Medical Equipment			376,603	4,535	150,143			531,281
Accumulated Depreciation	(83,372,375)		(99,788)	(80,357)	(191,544)			(83,744,063)
Total Fixed Assets	33,490,892	-	597,529	11,168	360,457	-	-	34,460,046
Other Assets								
Due from Weserly Hospital					265,878		(265,878)	0
Due from Dr. Benoit					640,504			640,504
Due from Drs. Iovino					386,719			386,719
Due from Dr. Weaver					79,100			79,100
Due from Women's Health of West					260,068		(260,068)	(0)

/ tes
Balance Sheet
As of May 31, 2012

Due from Ocean Myst MSO					114,213		(114,213)	0
Due from THW Community Health					742,532		(399,849)	342,683
Security Deposits Asset					3,900			3,900
Due from Related Parties	5,660,645	(795,938)					(4,864,707)	-
Other Assets	513,420		25,000					538,420
Deferred Financing Costs, Net	170,750							170,750
Total Other Assets	6,344,815	(795,938)	25,000	-	2,492,914	-	(5,904,715)	2,162,076
TOTAL ASSETS	$ 66,892,595	$ 194,610	$ 1,563,220	$ 209,184	$ 3,534,360	$ 131,696	$ (7,110,306)	$ 65,415,360
LIABILITIES & EQUITY								
Liabilities								
Current Liabilities								
Line of Credit	4,040,700							4,040,700
Current Portion of Long-Term Debt	2,592,099							2,592,099
Accounts Payable								
Accounts Payable	11,809,503	6,338	670,526	116,070	251,780	26,648		12,880,866
Accrued Expenses	7,011,443		9,500					7,020,943
Accrued Payroll	4,294,313		4,197					4,298,510
Amounts due To Third Party Payors	653,392							653,392
Accounts Payable - Affiliates						-		-
Total Accounts Payable	23,768,651	6,338	684,222	116,070	251,780	26,648	-	24,853,710
Other Current Liabilities								
Bonus Payable					143,386			143,386
Bad Debt Reserve			69,674	-				69,674
401K Safe Harbor Payable			31,414	59,505	195,843	13,195		299,957
Due to Affliates			399,849		242,247		(642,097)	(0)
Due to NSHC				-				-
Due to Ocean Myst MSO				65,254			(65,254)	0
Due To Atlantic Medical Gorup			(40,967)	260,068		114,214	(374,281)	(40,966)
Sales Tax Payable			19					19
401K Payable			2,363					2,363
Accrued Payables				24,700	-	5,000		29,700
Accrued Payroll				33,938	174,811	11,672		220,421
FSA Payable			(1,603)	385	(1,438)	(115)		(2,772)
Malpractice Insurance Accrual			3,347	311,049	-			314,396
Total Other Current Liabilities	-	-	464,096	754,899	754,849	143,965	(1,081,632)	1,036,176
Total Current Liabilities	30,401,450	6,338	1,148,318	870,969	1,006,629	170,613	(1,081,632)	32,522,686
Long Term Liabilities								
Long Term Debt	8,380,775							8,380,775
Asset Retirement Obligation	1,425,678							1,425,678
Additional Pension Liability	26,310,958							26,310,958
Note Payable - Pantheon Lease			276,357					276,357
Due to Westerly Hospital			5,844,699	102,152	-		(6,028,675)	(81,824)
Malpractice Tail Ins. Accrual				103,152	168,078			271,229
Total Long Term Liabilities	36,117,411	-	6,121,056	205,304	168,078	-	(6,028,675)	36,583,173
Total Liabilities	66,518,861	6,338	7,269,374	1,076,273	1,174,707	170,613	(7,110,307)	69,105,859
Equity								
Unrestricted Net Assets	(11,274,797)	133,522	(3,498,758)	217,300	4,559,415	(23,847)		(9,887,166)
Temporarily Restricted	2,732,069	54,750						2,786,819
Permanently Restricted	8,916,462							8,916,462
Net Income			(2,207,395)	(1,084,388)	(2,199,762)	(15,070)		(5,506,615)
Total Equity	373,734	188,272	(5,706,153)	(867,089)	2,359,653	(38,917)	-	(3,690,500)
TOTAL LIABILITIES & EQUITY	66,892,595	$ 194,610	$ 1,563,220	$ 209,184	$ 3,534,360	$ 131,696	$ (7,110,307)	$ 65,415,359
	(0)	-	-	-	-	-	(1)	(1)

COMMUNITY HEALTH OF WESTERLY INC. CONSOLIDATING STATEMENT OF OPERATIONS ($ 000s) 7 Months Ending 5/31/2012		YEAR-TO-DATE ACTUAL								
		The Westerly Hospital	Foundation	North Stonington	AMG	Women's Health Of Wstrly	Ocean Myst MSO,LLC	CHOW	Consol/ Elims	Consol-dated
Unrestricted Revenues:	Inpatient acute	47,386			-	-				47,386
	Outpatient acute	98,815		3,374	6,628	2,149				111,166
	Charges	-			-	-	-			-
	Other contractual income	-			2,157	-	572		(2,719)	10
	Gross Patient Revenues	**146,201**	**-**	**3,374**	**8,985**	**2,149**	**572**	**-**	**(2,719)**	**158,562**
Deductions From Revenue:	Contractual allowance	90,799		2,169	3,456	1,379				97,803
	Disproportionate share	1,189			-	-				1,189
	Uncompensated care	1,043			-	-				1,043
	Total Deductions From Revenue	**93,031**	**-**	**2,169**	**3,456**	**1,379**	**-**	**-**	**-**	**100,035**
	Net Patient Revenues	**53,170**	**-**	**1,205**	**5,529**	**770**	**572**	**-**	**(2,719)**	**58,527**
Total Other Operating Revenue		1,053	627	23	-	2	-		(627)	1,078
TOTAL NET OPERATING REVENUE		**54,223**	**627**	**1,228**	**5,529**	**772**	**572**	**-**	**(3,346)**	**59,605**
Operating Expenses:	Salaries and wages	23,359	85	1,171	3,903	930	356		-	29,804
	Vacation and sick accrual	206			-	-				206
	Temporary help	455			-	-	-			455
	Employee benefits	9,750	22	315	769	238	148			11,242
	Salaries, wages and benefits	-			-	-				-
	Total salaries and benefits	33,770	107	1,486	4,672	1,168	504	-	-	41,707
	Workers compensation	194			-	-	-			194
	Administrative fees	-			-	-				-
	Net admin & billing allocations	-			-	-				-
	Professional fees	1,030	-	93	164	77	63		-	1,427
	Medical/surgical supplies	3,719		109	110	57				3,995
	Drugs	1,807		13	2	45				1,867
	Other supplies	1,232		34	-	11	4			1,281
	Utilities	892	12	23	34	10	2			973
	Purchased / leased services	7,190	-	775	1,141	149	8		(2,719)	6,544
	Insurance	886		77	196	172	-			1,331
	Bad debts	4,595		191	64	10				4,860
	Leases and rentals	270		543	961	148	1			1,923
	Depreciation	3,167		57	51	2				3,277
	Interest	622		5	-	-				627
	Other expenses	584	36	31	439	7	5			1,102
TOTAL OPERATING EXPENSES		**59,958**	**155**	**3,437**	**7,834**	**1,856**	**587**	**-**	**(2,719)**	**71,108**
OPERATING INCOME (LOSS) BEFORE RESTRUCTURE		(5,735)	472	(2,209)	(2,305)	(1,084)	(15)	-	(627)	(11,503)
RESTRUCTURE COSTS		1,012								1,012
OPERATING INCOME (LOSS)		**(6,747)**	**472**	**(2,209)**	**(2,305)**	**(1,084)**	**(15)**	**-**	**(627)**	**(12,515)**
Non-operating Items:	Interest income				-	-				-
	Realized gain on sale of stock	115	60		105	-				280
	Contributions	117			-	-			627	744
	Other than temporary loss	-			-	-				-
NON-OPERATING REVENUE AND EXPENSE		**232**	**60**	**-**	**105**	**-**	**-**	**-**	**627**	**1,024**
REVENUES & GAINS OVER (UNDER) EXPENSES		**(6,515)**	**532**	**(2,209)**	**(2,200)**	**(1,084)**	**(15)**	**-**	**-**	**(11,491)**
Other Net Asset Adjustments:		-			-					-
	Change in Accounting Priciple	-			-	-				-
	Transfers to Parent Corp	(3,304)			2,340	762	202			-
	Foundation trnsfrs; net assets released	626	(626)		-	-				-
	Unrealized gain/loss investments	231	(8)		-	-				223
	Minimum pension liability adjustment	-			-	-				-
INCREASE/DECREASE IN UNRESTRICTED NET ASSETS		**(8,962)**	**(102)**	**(2,209)**	**140**	**(322)**	**187**	**-**	**-**	**(11,268)**

Exhibit 3

CURRICULUM VITAE

STEPHEN L. CHABOT, M.D.

Date of Birth:	June 22, 1953
Place of Birth:	Southington, Connecticut
Citizenship:	USA
Marital Status:	Married
Home Address:	7 Bubbling Brook Road, Walpole, MA 02081
Home Phone:	(508) 668-4376
Fax:	(781) 794-2215
E Mail:	Schabot@gatewayhealth.org
Business Address:	Gateway Healthcare, Inc. 101- 103 Bacon Street Pawtucket, RI 02860
Business Telephone:	(401) 722-3560

EDUCATION:

Undergraduate:	University of Rhode Island, Kingston, RI Bachelor of Arts, 1975
Honors:	Honors Program in Biology
Medical School:	Brown University, Providence, RI Doctor of Medicine, 1984

POST GRADUATE TRAINING:

Internship:	Harvard Medical School, Salem Hospital, Salem, MA Internal Medicine, June 1984 to June 1985.
Residency:	Brown University Psychiatric Residency Program, June 1985 to June 1988.

PROFESSIONAL LICENSES AND CERTIFICATION:

Board Certification, American Board of Psychiatry and Neurology # 36080 November1992
Rhode Island Medical License # 6763
Massachusetts Medical License # 54981

ACADEMIC APPOINTMENTS:

Clinical Assistant Professor in Family Medicine/Psychiatry
Brown University Medical School, December 1990 to present

OTHER APPOINTMENTS:

Medical Director	Gateway Healthcare Inc., Pawtucket, RI November 1992 – present
Medical Director	South Shore Center (Gateway Affiliate) July 2010 – present Caritas House (Gateway Affiliate) July 2010 – present
Chief of Psychiatry/ Director of Psychiatric Medical Education	Memorial Hospital of Rhode Island July 1, 2004 – present
Chief of Psychiatry	Braintree Medical Associates/HMO BLUE July 1988 to June 2000

MEMBERSHIP IN SOCIETIES:

American Psychiatric Association
Massachusetts Medical Society
Massachusetts Psychiatric Society
Brown Medical Society

PUBLICATIONS:

"Panic Disorder in Cardiology Outpatients", Psychosomatics, May 1989

Exhibit 4

Market Feasibility Study

Inpatient and Organized Outpatient Behavioral Health Services

Submitted by

Diamond Healthcare Corporation

June 2012

Section I

Introduction, Purpose and Methodologies Used to Conduct the Market Feasibility Study. Diamond Healthcare Corporation ("Diamond") is working with Westerly Hospital Healthcare ("Westerly") to evaluate opportunities to develop behavioral health services. Diamond conducted an on-site visit May 3rd and 4th, 2012. The on-site visit was supplemented by data and demographic analysis, and a financial review. The study examines the need for services, existing competitor programs, environment of care needs, regulatory requirements and financial considerations.

Diamond's Background. Diamond Healthcare Corporation is a nationally recognized psychiatric services organization. Diamond was founded in 1985 and is headquartered in Richmond, Virginia with a regional office in Houston, Texas. Diamond is one of the leading psychiatric management and consulting services organizations in the United States. Organizationally consisting of four (4) Divisions (Diamond Management Services, Diamond Consulting Practices Group, The Pavilion and The Farley Center at Williamsburg Place and Diamond "REACH" Employee Assistance Program-Workplace Solutions), Diamond provides psychiatric services in a variety of partnering relationships to over eighty (80) hospitals in twenty-eight (28) states and the District of Columbia.

Diamond has developed a unique approach to assist healthcare organizations establish and operate high quality psychiatric programs for their communities. Diamond's approach enhances a hospital's ability to provide clinically and financially sound psychiatric services that are tailored to the needs of both the hospital and the hospital's service community. Further, these services can be delivered in a manner that is consistent with the hospital's mission and identity.

Facility Background. Westerly is a 125-bed acute care hospital located in Westerly (Washington County), Rhode Island ("RI"). Westerly is currently in receivership and is operated under the overall control of a State-appointed Magister. Westerly provides a range of medical, surgical and obstetrical services including but not limited to:

- Intensive care services;
- Emergency services;
- Cardiac Catheterization Laboratory services;
- Oncology services;
- Orthopedic services including joint replacement;
- Renal Dialysis services;
- Lithotripsy services;
- Rehabilitation services including physical therapy and cardiac rehabilitation services;
- Wound care services; and
- A range of diagnostic laboratory and imaging services.

Westerly does not provide inpatient or outpatient behavioral health services as part of their array of existing services.

Acute Care. In 2010, Westerly provided 17,663 days of inpatient acute care services to a total of 4,238 patients. Westerly served an acute care Medicare and Medicaid patient population which accounted for 47.6% and 1.6% of their 2010 total acute care patient days, respectively.[4]

Section II

The National Operating Environment. Historically, the hospital-based behavioral health provider operated services that were therapeutically staffed by physicians, inpatient-oriented, and treated a patient population with few medical co-morbidities. Outpatient services were generally provided through individual physician or clinician practices. High-acuity patients were usually referred to State-operated inpatient facilities or private-sector specialty programs (e.g. residential treatment programs for sexual predators, inpatient programs for patients with co-occurring developmental disabilities and psychiatric issues, etc.).

[4] American Hospital Directory, May 2012.

Over the past decade, there have been significant changes in the behavioral health operating environment, particularly in the areas of State and Federal resource allocations (i.e., beds and dollars) and treatment funding for the publicly-supported patient population. These changes include:

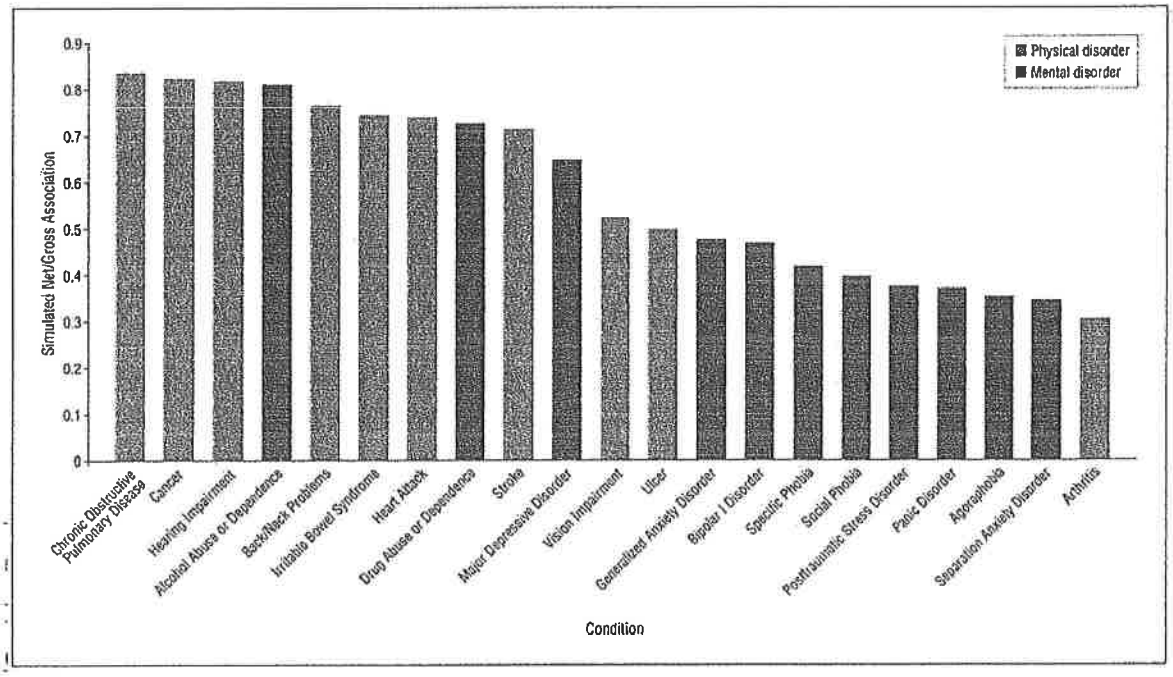
- *Reductions in the funding available for treatment of publicly-supported behavioral health patient populations*;
- *Increased numbers of psychiatric emergencies* presenting to acute care hospitals;
- Increased demand for treatment services oriented to the needs of older adults with *co-occurring physical conditions* and psychiatric needs;
- *Increased integration of psychiatric services into medical treatment* of stroke, cardiopulmonary, cancer and women's health patients;
- *Increased demand for consultation and liaison services* provided to community-based providers of services to older adults such as assisted-living, personal care and nursing home facilities;
- *Increased use of multi-disciplinary team approach* to psychiatric treatment;
- *The development and increased application of pharmacogenetics as part of the overall treatment protocol*;
- *Increased use of telemedicine to augment availability and access* to behavioral health assessment treatment services; and
- *Changes in the demand and reimbursement for behavioral health services* enabled by the passage of the Patient Protection and Affordable Care Act ("PPACA") legislation for insurance coverage, including mental health parity (the "Wellstone Act").

Changes in the funding available for treatment of publicly-supported behavioral health patient populations. States and local governments are under increased fiscal pressure as the slow economic environment has eroded their tax base. State and local governments have responded to the reduced tax revenue by *reducing reimbursement for services or reducing the scope of services available to publicly-funded patient populations.*

Increased numbers of psychiatric emergencies presenting to acute care hospitals. Nationally, approximately *26% of patients being treated in a hospital's emergency department have a psychiatric primary or secondary diagnosis.*

Studies have indicated that as hospitals like Westerly are assuming greater responsibility for providing the care for the chronic psychiatric populations, acute care hospital emergency departments are becoming a frequently used "portal of entry" to receive services. The increased difficulties surrounding the disposition of behavioral health patients presenting to Emergency Departments has caused congestion with reduced operating efficiencies, increased resource costs and increased lengths of stay including higher frequencies of "patient boarding" in the Emergency Department. Compounding the increased volumes of patients with behavioral health issues presenting to the Emergency Department, the increased utilization of existing psychiatric bed resources and lack of services has resulted in a decrease in the capacity available to admit patients needing to be referred to inpatient care.

Increased demand for treatment services oriented to the needs of older adults with co-occurring physical conditions and psychiatric needs. As the population of the United States ages, the frequency of patients being admitted to hospitals with multiple health conditions also increases. In 2007, a study conducted for the National Institutes of Medicine found that 53.4% of the U. S. population has at least one (1) of the following physical or mental health conditions[5]:



Household Population, Archives of General Psychiatry, 2007 October; 64(10) 1180-1188.

The impact of addressing the needs of a patient population presenting with both a psychiatric and a medical condition requiring active treatment changes the scope of the services provided in a psychiatric unit from one addressing the needs of a physically "healthy" population with a behavioral issue, to treating a patient population having both a physical health and a behavioral health issues requiring treatment.

Increased integration of psychiatric services into medical treatment of stroke, cardiopulmonary, cancer and women's health patients. Numerous studies have been published in recent years highlighting improvement in patient outcomes when appropriate behavioral health interventions have been included to treat depression in patients with stroke, cardiac and pulmonary disease, and cancer. As these studies became more prevalent, there has been a corresponding increase in the demand for behavioral health consultations and interventions for patients in medical-surgical units exhibiting the symptoms of depression and affective behavior. *Many hospital-based behavioral health programs have developed consultation and liaison services tailored to the needs of the hospital's medical-surgical units, clinics, emergency departments and other services.*

Increased demand for consultation and liaison services provided to community-based providers of services to older adult and geriatric patients, such as assisted-living and nursing home facilities. Community-based residential settings include congregate or senior housing, senior hotels, foster care, group homes, day centers (where people reside during the day) and nursing homes. *Community-based services for older adult and geriatric patients, such as assisted-living and nursing home facilities have become primary referral sources for inpatient and outpatient psychiatric programs.*

Increased use of a multi-disciplinary team approach to psychiatric treatment. Responding to the increased demand for cost-efficient services, psychiatric programs have increased their use of non-physician clinical professionals. *Non-physician clinical professionals include licensed clinical social workers, licensed professional counselors, clinical psychologists and masters-prepared nurse clinicians.* The multi-disciplinary approach to care provision has allowed nursing

staff to focus on the medical and educational aspects of the patient's care with clinical therapists becoming the primary providers of therapeutic interventions. Further, *the primary treatment modality has shifted from the individual therapy model to the group process therapy model.* The group process therapy treatment model has proven to be as efficacious as the individual therapy model and better suited to a facility-based environment.[6] *The group process model allows a program to effectively utilize treatment resources, while addressing the treatment needs of a higher patient volume.*

The development and increased application of pharmacogenetics as part of the overall treatment protocol. Pharmacogenetics refers to genetic differences in metabolic pathways which can affect individual responses to drugs, both in terms of therapeutic effect as well as adverse effects. *The ability to identify those patients who will respond well to psychotropic drug treatment or who will be at a higher risk for adverse effects could help clinicians avoid lengthy ineffective drug trials and limit patients' exposure to those effects.* Moreover, better predictability of treatment response early in the course of a patient's illness *can result in enhanced medication adherence, a significant predictor of relapse prevention.*

Telemedicine. Telepsychiatry, or telemedicine, is a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas. It can connect patients, psychiatrists, physicians, and other healthcare professionals through the use of television cameras and microphones. *Telemedicine currently provides an array of services including but not limited to diagnosis and assessment, medication management, and individual and group therapy.* Telepsychiatry is currently one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas.

Outpatient psychiatric sessions under Medicare are reimbursed the same as "face-to-face" encounters when appropriately coded as telemedicine visits. The psychiatrist is reimbursed according to the Medicare Physician's Fee Schedule (MPFS) and the hospital receives a 'facility fee' for hosting the encounter. There

[6] McRoberts et al., (1998). Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective. Group Dynamics, 2, 101-117.

is also increased coverage by Medicaid and commercial payers for medically-necessary services appropriately provided using telemedicine.

Patient Protection and Affordable Care Act (National Health Insurance) and Mental Health Insurance Parity Legislation. In March 2010, the PPACA legislation was signed into law. Included in the PPACA are provisions that makes available health insurance coverage for approximately 32 million currently uninsured individuals, mandates coverage of pre-existing conditions (including mental health disorders), expands coverage under Medicaid for psychiatric and substance abuse disorders, and re-affirms the provisions of the Wellstone Act. *It is expected that over the next few years, the impact of this legislation will be to increase utilization of mental health services in hospital-based programs.*

Employer-provided health plans have for years, routinely set stricter treatment limits and imposed higher out-of-pocket costs on mental health care than any other medical care. On September 18, 2007, the Senate unanimously passed a revised version of the *Mental Health Parity Act of 2007.* In the U.S. House of Representatives, a similar piece of legislation, the *Paul Wellstone Mental Health and Addiction Equity Act* ("Wellstone Act") was passed on March 5, 2008. These two pieces of legislation were passed by Congress and signed into law in July, 2008. This legislation corrected the limitations of the Mental Health Parity Act of 1996, extending the "on par" to co-payments and deductibles.

The changes in the operating environment has necessitated a change in how hospital-based behavioral health providers are configured and deliver services. Successful state-of-the-art hospital-based, behavioral health programs generally share the following *operational and market characteristics*:

Operational Characteristics

- The ability to provide *integrated and coordinated* services to multiple patient populations throughout the inpatient and outpatient continuum (i.e., 23-hour crisis observation services, crisis stabilization inpatient beds, acute and specialty inpatient beds, organized outpatient and aftercare services);

- The ability to provide effective, pro-active outreach consultation, intake and assessment services to other hospital departments as well as to community care providers;
- The ability to address *both* the psychiatric and medical needs of the adult and older adult patient population;
- The ability to provide services where the goals of the physicians and the hospital are well-aligned and mutually supportive;
- The ability to provide services using a well-integrated, clinical-nursing therapeutic model with staff trained to address the higher acuity and co-morbid patient population;
- The ability to provide an integrated and coordinated continuum of inpatient and outpatient services operated as an *organized and financially sound product-line* of the hospital; and
- The ability to provide services in a secure operating environment conducive to efficient staffing, patient safety and providing high quality patient and family centered care.

Market Characteristics

- Operates as part of a *distributed network of inpatient and outpatient program services* within the market;
- Operates programs which have a *diverse patient payer* mix;
- Operates programs with a reputation in the market for providing high quality patient care;
- Operates programs that enjoy strong market presence in multiple market segments (e.g., child and adolescent services, adult services, older adult services, specialty services such PTSD treatment, depression treatment, etc.); and
- Operate programs that are *appropriately coordinated* with community-based program services.

The Behavioral Health Reimbursement and Funding Environment. The two largest payers for behavioral health services are Medicare (i.e., Medicare for the aged and for the disabled) and Medicaid. Changes in reimbursement for Medicare patients both on the inpatient and outpatient basis have impacted revenues. Economic conditions combined with changes in Federal policy have stressed State-level funding and resulted in reduced funding for community-based behavioral health programming and reimbursement for patients covered under the Medicaid program.

Factors such as the implementation of Medicare's inpatient and outpatient prospective payment system for behavioral health services, the implementation and growth of managed Medicare and Medicaid programs, and the growth of managed care as a primary private insurance coverage, have impacted how behavioral health services are delivered.

Medicare Reimbursement. Inpatient Reimbursement. The most recent change impacting behavioral health services was implementation of a prospective payment reimbursement system for inpatient hospital-based psychiatric units ("IPPF") in 2005. The IPPF is per diem based payment system that includes adjustments for factors such as DRG weight, wage indexing, rural location, teaching institutions and length of stay variations. The base rate is a bundled amount including routine operating, ancillary and capital-related expenses. The prospective system of reimbursement applies only to hospital-based inpatient psychiatric facility units or free-standing inpatient psychiatric facilities classified as psychiatric hospitals. These units/facilities have received distinct-part unit designation and are reimbursed separately from the overall Medicare Prospective Payment System.

At the same time that IPPF was changing the nature of reimbursement under traditional Medicare coverage for psychiatric services, the growth of managed Medicare was also impacting the level of utilization and reimbursement. In 2011, the penetration rate for Medicare Advantage was 35.42% of the total Medicare enrollees in Rhode Island. In comparison, the penetration rate for the primary Westerly market was 29.86% for the Rhode Island (Washington County) portion of the market and 14.38% for Connecticut (New London County) portion of the market.

Managed Medicare products are generally considered to fall into the category of "risk contracts" since a set amount per covered life is provided to the carrier and the organization can lose money if it overspends this allotment.[7] As a result of this dynamic, managed Medicare products have employed various strategies to limit utilization and reimbursement. In behavioral health, these strategies have

[7] Sakauye, K, MD, Blank, K., MD, Cohen, C.I., MD, et. al., Medicare Managed Mental Health Care: A Looming Crisis, Psychiatric Services, July 2005, 56:7, pages 795-97.

included use of high co-payment (i.e. "cost-sharing") requirements for outpatient behavioral health services, use of "fail-first" primary care requirements (i.e., specialty services are used as a documented last resort) and implementing increased acuity admission criteria for accessing inpatient treatment.

Medicaid Reimbursement. Managed Medicaid has become the pre-dominant form of payment for non-Medicare publicly funded patient populations. In 2010, 71.64% of all Medicaid enrollees were covered under a managed care Medicaid product.[8] In 2010, in Rhode Island, 68.49% of all Medicaid enrollees are in a managed care product. In Connecticut, 63.34% of Medicaid enrollees are in a managed care product. As with all managed care products, the impact on providers is a reduction in inpatient utilization and reimbursement with patients directed to the lowest level of acuity consistent with their treatment needs.

Outpatient Reimbursement. In general, hospitals' reimbursement for organized (i.e., hospital-based) outpatient behavioral health services is available through a variety of payers. These payers include Medicare, Blue Cross, commercial insurers, managed care organizations and to a limited extent, other governmental payers. Depending on the payer, the patient will be responsible for a portion of the reimbursement of co-payment. The average co-payment amount is approximately twenty percent (20%) of the total amount allowed for the service.

Disproportionate Share Reimbursement. Under the provisions of the PPACA, beginning in 2014, there will also be a gradual phasing-out of disproportionate share funding as the number of uninsured patients ("i.e., uncompensated care") is reduced by mandatory insurance coverage for services. In hospitals with high Medicaid and uncompensated care volumes, the disproportionate share allocation has represented a revenue source supporting that patient population. Disproportionate share allocations are calculated on a hospital-wide basis. Organized hospital-based inpatient behavioral health programs that serve large publicly-funded (i.e., Medicaid) or uncompensated care behavioral health

[8] Centers for Medicare and Medicaid Services, Medicaid Managed Care Enrollment as of December 31, 2010, March, 2011.

populations represent a significant addition to the overall disproportionate share allocation.

Impact of the PPACA on Reimbursement. It is anticipated that implementation of the PPACA will impact on the State funding of services for the publicly-insured patient. The immediate near-term effect of adoption of the PPACA should be favorable to hospitals as more patients will have some type of insurance coverage, pushing down the cost of uncompensated care. The medium and longer-term effect is much more uncertain. *In addition to phasing-out disproportionate share reimbursement*, the changes in the operating environment resulting from the efforts by the federal and state governments, private insurance companies and business coalitions to reduce and contain health care costs will impact on how services are delivered. Imbedded in the PPACA are concepts such as family-centered care, medical homes, and incentives related to outcome improvement.

Section III

The Continuum of Care in Behavioral Health. The continuum of psychiatric services is defined as including inpatient, organized outpatient and aftercare levels of service. The various levels of care are related to the medically-necessary intensity of service required to meet the needs of the patient. The services in each level of care address a portion of the overall psychiatric needs of the at-risk population (i.e., a general adult psychiatric unit), or provides the specialized care required to address the treatment needs of specific patient populations (e.g., child and adolescent services, geropsychiatric services, chemical dependency services, etc.).

Examples of varying levels of *inpatient service intensity* include:

- *Inpatient Crisis Stabilization Units.* Crisis stabilization units are oriented to the needs of patients requiring short term (i.e., 2 to 3 days) inpatient stays usually related to stabilizing an acute episode of a chronic mental illness or substance abuse condition. Medication management and initial psychotherapeutic intervention is begun during the patient's stay in the crisis stabilization unit during which a therapeutic evaluation is completed which indicates that the patient requires

a longer duration of inpatient therapeutic intervention, discharge to organized outpatient program treatment, or other disposition.

- *Acute Intensive Care Inpatient Units.* Acute psychiatric intensive care units ("psychiatric ICU") are usually eight (8) to ten (10) bed units with high staffing ratios and monitoring capabilities. The patient populations in these units are acutely ill and, in many instances, at high risk of harming themselves or others. A significant percentage of the patients treated in psychiatric ICUs are patients awaiting an initial adjudication and referral to a secure State Hospital facility. The primary intervention modality employed in psychiatric ICUs is psychotropic medication management. The psychiatric ICU is a secure unit with average lengths of stay of between three (3) and seven (7) days.
- *Acute Child and Adolescent Inpatient Units.* The acute child and adolescent inpatient unit usually addresses the acute psychiatric and/or substance abuse treatment needs of a child and adolescent (i.e., 10 to 17 years old) patient. Treatment is multi-disciplinary in nature involving individual and group therapy as well as medication management. Treatment may also include detoxification services. The average length of stay in child and adolescent acute inpatient units is approximately seven (7) days.
- *Acute Adult Inpatient Units.* The acute adult inpatient unit provides a multi-disciplinary approach to treatment involving individual and group therapy as well as medication management. The patient population for an acute inpatient treatment unit is usually a higher functioning patient population with an acute episode of a mental illness/disorder. The average length of stay in acute adult inpatient units is between five (5) and seven (7) days.
- *Acute Geriatric Inpatient Units.* The Acute Geriatric inpatient units treat both high and low functioning patients. High functioning geriatric patients generally have an acute episode of a mental illness/disorder, in many instances severe depression. These patients are able to participate in individual and group process treatment modalities. The lower functioning geriatric patient is usually cognitively impaired and has been admitted to the inpatient unit with an acute psychiatric episode for medication management and behavioral management interventions. The average length of stay in geriatric acute inpatient units is between eight (8) and twelve (12) days.

- *Specialty Care Inpatient Units*. Specialty care inpatient are designed to address the treatment needs of patients with a specific behavioral health condition or disorder such as post traumatic stress disorder ("PTSD"), co-occurring psychiatric and substance abuse, severe depression including bipolar disorders. Specialty care units usually involve specialty funding (e.g., PTSD and Military/Tri-Care, Depression Centers with Federal grant funding, pharmacogenetics and drug trials). The average lengths of stay in specialty care units varies.

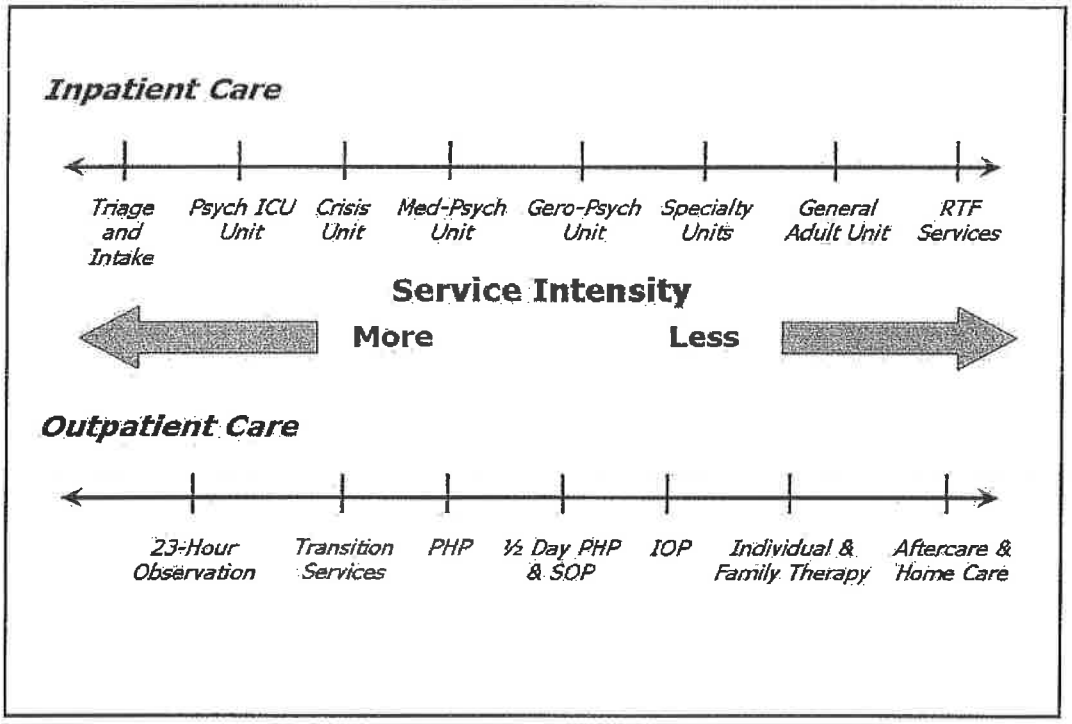
Examples of the varying levels of intensity provided through *hospital-based organized outpatient services* include:

- *23-Hour Observation Services*. These services are oriented to the needs of patients that can be stabilized in 23 hours or less usually related to an acute episode of a chronic mental illness or substance abuse condition. In most instances, these patients require medication management services in contrast to requiring more extended psychotherapy services. The *23-Hour Observation Services are outpatient services which are designed to increase throughput in the Emergency Room and to provide appropriate triage to the patient population who may or may not require inpatient treatment.*
- *Partial Hospitalization Program ("PHP") services*. PHP services provide the highest level of outpatient services intensity. Partial hospitalization is a time limited, outpatient treatment modality for individuals with an active psychiatric or behavioral illness. *Partial hospitalization is an alternative to inpatient hospitalization* offering intensive, coordinated, multi-disciplinary treatment services on an outpatient basis. PHP services are used by individuals who can maintain themselves at a functional level at home or in a community setting for at least part of the day. The behavioral health PHP is between four (4) and six (6) hours in duration each day, with treatment programming prescribed by the psychiatrist to meet a patient's specific needs. Treatment modalities used in a PHP include: group, individual, and recreation therapies, as well as other treatment services (e.g., medication management).

- *Intensive Outpatient Program ("IOP") services.* IOP services are highly structured, coordinated, multi-disciplinary treatment programs provided in a hospital-based outpatient setting. Patients usually receive treatment for up to three (3) times per week to each client. IOP services usually involve nine (9) hours of services per week. IOP services are physician-directed and are based on an individualized treatment program developed for the patient following a comprehensive assessment and treatment planning process. The treatment modalities used in IOPs include group process therapy, individual and family therapy, medication management, and other related psychiatric treatment modalities.
- *Chemical Dependency Intensive Outpatient Program ("CD-IOP") services.* CD-IOP services are outpatient treatment services provided to persons experiencing significant impairment in their daily functioning as a result of chemical dependency/substance abuse but not requiring an inpatient level of treatment. CD-IOP services are usually provided as part of an overall range of IOP and CD-IOP behavioral health outpatient services.
- *Consultation and Liaison Services.* Consultation and liaison services are an extension to other hospital programs and nursing units of the hospital provided by psychiatric program staff. Consultation and liaison services are provided by the psychiatric clinical staff at the request of other physicians or healthcare professionals. These services include performing preliminary mental health assessments and providing information on such issues as medication management, coping with a patient's psychiatric needs, and assisting with the referral and disposition of the patient to an appropriate level of care.

Exhibit One graphically displays the continuum of facility-based behavioral health services.

Exhibit One. Continuum of Facility-Based Behavioral Health Services



Psychiatrist Practice and Physician Extender Services. Psychiatrists provide psychiatric services in various settings. These settings include private practice, community mental health centers, hospital-based practices, academic medical centers and medical schools. Psychiatrists involved with hospital-based psychiatric programs typically have practices that have two major practice components:

- A facility-based component (i.e., services provided in a hospital setting); and
- A private practice component (i.e., the psychiatrist's office practice).

The facility component involves the psychiatrist as an attending physician, providing psychiatric consultations at the request of other physicians and providing on-going psychiatric care and medication management for patients. In

the facility component role, the psychiatrist provides the necessary medical direction of the patient's care (including medication management) and does not generally provide direct therapy services.

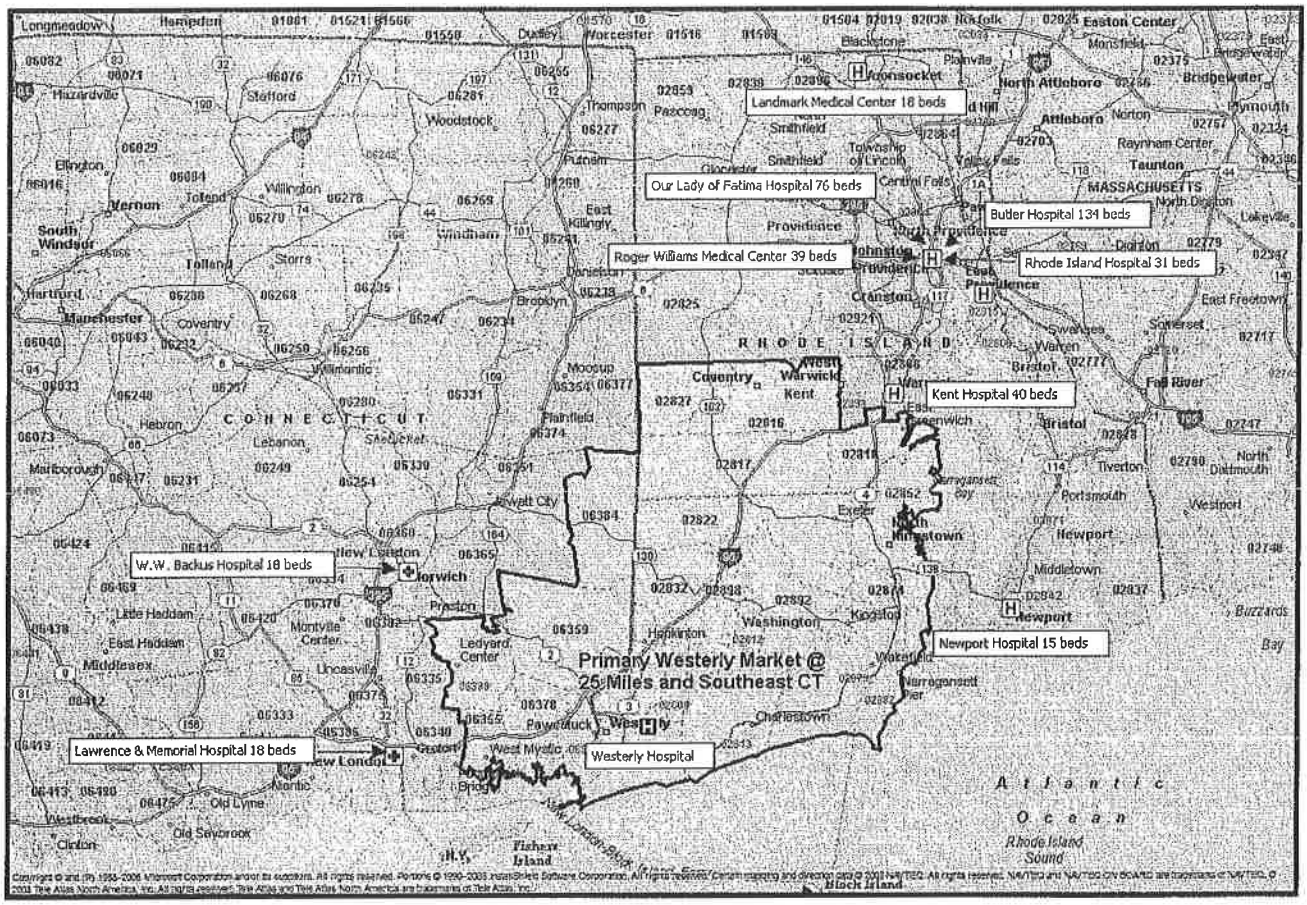
In the private practice role, the role of the psychiatrist has evolved from providing the traditional individual therapy sessions to providing initial consultations and evaluations, determining medical necessity, providing medication management and directing the overall care management provided to the patient by physician extenders such as clinical psychologists, licensed professional counselors, licensed clinical social workers, and advanced practice psychiatric nurses.

In rural areas, *telemedicine* has become a state-of-the-art response to the lack of physician resources in areas with a physician shortage. Federal programming provides reimbursement for telemedicine in a designated rural market, including start-up funding.

Section IV

The Market for Behavioral Health Services. The primary market for inpatient and outpatient behavioral health services at Westerly is comprised of all or portions of Kent and Washington Counties in RI, and New London County in Connecticut ("CT"). The primary market is comprised of persons residing within a radius of approximately twenty-five (25) miles of Westerly in RI and CT. Exhibit Two presents a map of the primary market for behavioral health services at Westerly.

Exhibit Two. Map of Primary Market for Behavioral Health Services at Westerly



Exhibits Three and Four identify the specific towns and cities included in the primary market as well as selected demographic information regarding the overall population of the primary market and the United States by age group.

The market includes all or portions of Washington and Kent Counties in Rhode Island and New London County in Connecticut. The market reflects the geographic areas from which Westerly has historically drawn medical-surgical patients.[9] The following Table lists the cities and towns comprising this primary market area.

[9] Table 3 of the Report prepared for the Rhode Island Department of Health Hospital Market Concentration and Market Share in Rhode Island, June 2009 indicates that in 2007 Westerly received 34% of its inpatient discharge volumes from Connecticut.

Exhibit Three. Towns and Cities Included in the Primary Westerly Market

Zip Code	City/Town	County
02827	Greene	Kent
02816	Coventry	Kent
02818	East Greenwich	Kent
02852	North Kingstown	Washington
02822	Exeter	Washington
02898	Wyoming	Washington
02832	Hope Valley	Washington
02892	West Kingston	Washington
02812	Carolina	Washington
02874	Saunderstown	Washington
02894	Wood River Junction	Washington
02804	Ashaway	Washington
02808	Bradford	Washington
02813	Charlestown	Washington
02891	Westerly	Washington
02882	Narragansett	Washington
02807	Block Island	Washington
06384	Voluntown (CT)	New London
06359	North Stonington (CT)	New London
06339	Ledyard (CT)	New London
06378	Stonington (CT)	New London
06379	Pawcatuck (CT)	New London

The population for the primary market is estimated to be 181,640 persons in 2012, growing to a total population of 184,925 persons by 2017 for a five year growth rate of 1.8%. The following Exhibit summarizes the estimated 2012 and projected 2017 populations for the primary market.

Exhibit Four. Selected Demographics, Primary Market, Westerly

Age Group	2012 Population	Percent of Total	2017 Population	Percent of Total
Under 18	38,235	21.0%	36,205	18.5%
18 to 54 (General Adult)	85,505	47.1%	81,745	44.2%
55 to 64 (Older Adult)	28,175	15.5%	32,360	17.5%
65 and Older (Geriatric)	29,725	16.4%	34,615	17.8%
Totals	**181,640**	**100.0%**	**184,925**	**100.0%**

Source: Claritas Population Estimates and Projections, 2012 and 2017.

In 2012, approximately *85,505* (47.1%) of the residents in the primary market were 18 to 54 years old. The adult population is projected to *decrease* by approximately *4,205 persons (4.4%) to 81,745* (44.2% of the total population) by 2017. In 2012, approximately *57,900 (31.9%)* of the residents in the primary

market were 55 years or older. The older adult and geriatric population is projected *to increase by approximately 9,075 (15.7%)* to *66,975* (36.3% of the total population) by 2017.

The Need for Inpatient, Outpatient, and Psychiatrist Services. The "need" in a market is affected by various factors including:

- The size and the age distribution of the population;
- Geographic considerations impacting access;
- Economic considerations such as insurance coverage and the size of the indigent and medically-underserved population; and
- Prevalence and utilization rates for various conditions in the population.

Need for Inpatient Psychiatric Services. Two different methodologies were used to estimate the need for inpatient psychiatric beds in the Westerly market:

- A *demand-based approach* using the most recently reported discharge and patient days use rates in Rhode Island; and
- A *prevalence-based approach* based on studies performed for the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH) and in the Surgeon General of the United States Report on Mental Health published in 1999.[10]

Demand-Based Approach. The demand-based method used to project the need for adult and geriatric inpatient beds is based on the historical (2009) use rate for adult and geriatric discharges and related patient days in Rhode Island.[11] The 2009 use rate is projected against the estimated 2012 and projected 2017 market populations to determine bed demand for adult and geriatric beds. The Rhode Island use rate was also applied to the Connecticut portion of the primary market.

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[10] U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999, pages 46 through 48.

[11] A demand-based approach is used by the State of RI to project need on a state-wide basis for the purpose of evaluating certificate of need ("CON") applications. These *use rates* are applied to the populations of the primary market to estimate/project need for general adult, older adult and geriatric beds in the Westerly market.

Historical Demand-Based Methodology. The following Table summarizes the basic historical Rhode Island discharge and patient day use rates for adult and geriatric patients utilizing *inpatient psychiatric services*:[12]

Exhibit Five. RI Psychiatric Discharges and Patient Days per 1,000 Population, 18 to 64 Years and 65 Years and Older, 2009

Age Group	2009 Population	2009 Discharges	2009 Patient Days	2009 Discharges per 1,000	2009 Patient Days per 1,000
18 to 64 Years	674,435	11,909	88,235	17.66	130.83
65 Years or Older	149,676	1,632	18,629	10.90	124.46
Total Adult and Geriatric	**824,111**	**13,541**	**106,864**	**16.43**	**129.67**

Applying the historical use rate to the estimated 2012 and projected 2017 population of the primary market area is presented on Exhibit Six.

Exhibit Six. Estimated 2012 and Projected 2017 Psychiatric Patient Days and Bed Need, Demand Approach, Westerly Market

Age Group	2012 Population	2017 Population	2012 Days	2017 Days	2012 Bed Need	2017 Bed Need
18 to 54 Years	85,505	81,745	11,185	10,695	31	28
55 to 64 Years	28,175	32,360	3,685	4,235	10	13
Total General Adult	113,680	114,105	14,870	14,930	41	41
65 Years or Older	29,725	34,615	3,700	4,310	10	12
Total Adult and Geriatric	**143,405**	**148,720**	**18,570**	**19,240**	**51**	**53**

Note: To be consistent with the RI CON approach of general adult and geriatric , the general adult and older adult need are combined as the general adult.

Based on applying the historical demand-based use rates for inpatient general adult and geriatric psychiatric services to the estimated and projected primary market area populations results in an estimated 2012 need for 41 general adult and 10 geriatric beds, increasing to 41 general adult and 12 geriatric beds by 2017.[13]

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[12] Zimmerman, Tables 4A and 5A.

[13] A *demand-based* methodology is used by the State of RI to project need on a state-wide basis for certificate of need purposes. The RI methodology has use rates for two (2) age groups – adult (18 to 64 years) and geriatric (65 years or older). For a consistent comparison with the *prevalence-based* methodology, applying the adult demand rate to the 55 to 65 population (i.e., older adult) of the primary market area results in the following bed breakdown:

- A 2012 estimate of 31 general adult, 10 older adult and 10 geriatric beds.
- A 2017 projection of 28 general adult, 13 older adult and 12 geriatric beds.

The demand-based need assumes that all patients needing services were able to access those services. For older adult and geriatric beds, two additional factors should be considered when determining bed sizing for the Westerly market. These factors are:

- *Availability of beds on demand.* With a geriatric demand estimate of ten (10) beds in 2012 and twelve (12) beds by 2017, establishing a geriatric unit smaller than fifteen (15) beds would reduce the "availability on demand" for these beds. The 2012 demand would result in an occupancy rate of 67%. At a demand rate of twelve (12) beds the occupancy rate would be 80%. The unit was sized to accommodate fluctuations in census above the demand-based ADC of 10 to 12 patients. Older adult patients (i.e., 55 to 64 years of age) could swing to either the general adult or the geriatric unit depending on census level.
- *Psychiatric patients in Nursing Homes.* Studies have indicated that there is a large patient population in nursing homes that have a primary psychiatric diagnosis warranting intervention and treatment. It is estimated that there are approximately 500,000 persons with mental illness[14] residing in U.S. nursing homes on any given day.[15] One consequence of the downsizing of state psychiatric hospitals has been the use of nursing homes as a de facto mental health institution. In 2005, 27.4% of new nursing home admissions indicated schizophrenia, bipolar disorder, depression or anxiety. The estimated percentages for Rhode Island and Connecticut were 25.0% and 22.2% respectively.[16] Applying those percentages to the nursing home patient population in the primary market indicated that there are approximately 710 nursing home residents in the Rhode Island portion of the market and 200 nursing home residents in the Connecticut portion of the market with diagnosable mental illness requiring intervention. Given the high utilization and of psychiatric beds in the State and the lack of available beds in the South County Region, it can be expected that these individuals represent an unexpressed need/demand for inpatient and related outpatient psychiatric services.

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[14] Excluding dementia.

[15] Fullerton, CA et al. Trends in Mental Health Admissions to Nursing Homes 1999-2005, Psychiatric Services.

[16] Grabowski, DC, Aschbrenner, KA, Feng, Z, and Mor, V. Mental Illness in Nursing Homes: Variations Across States, Health Affairs, Volume 28:3, 689-700.

Prevalence-Based Methodology. Need estimates are based on the prevalence rate of individuals with an acute mental illness requiring intervention in order to allow the individual to perform normal activities of daily living. These rates are applied to the primary and regional market populations to provide an estimate of the baseline population at-risk of needing treatment services. In general, approximately 14.0% of the general adult population (persons 18 to 54 years of age), 14.7% of the older adult population (persons 55 to 64 years of age) and 19.8% of the geriatric population (persons 65 years or older) have an acute mental illness appropriate for intervention. Approximately 14.9% of the at-risk child and adolescent and 20% of the total at-risk adult and older adult (65 and older are not included in this adjustment) have an acute mental illness appropriate for inpatient intervention.[17] Exhibit Seven summarizes the acute inpatient psychiatric bed need for the primary market.

Based on *national prevalence rates for inpatient psychiatric services*, it is estimated that the primary market can be expected to generate approximately *4,335* adult, older adult and geriatric psychiatric admissions, equating to approximately *67* inpatient beds. The 2012 older adult and geriatric population in the primary market is estimated to generate *2,025* acute psychiatric admissions equating to an *unadjusted need of 41 inpatient beds*. It is projected that despite the *projected decrease in the overall population* between 2012 and 2017, the *unadjusted need for older adult and geriatric beds will increase from 41 to 47 beds* as the population ages.

[17] Ibid.

Exhibit Seven. Adult, Older Adult and Geriatric Psychiatric Bed Need, Westerly Market, 2012 Estimated and 2017 Projected

Age Group	2012 Population	2017 Population	Percent Inpatient Psychiatric Services	2012 Estimated Patient Days	2017 Projected Patient Days	2012 Estimated Bed Need	2017 Projected Bed Need
18 to 54	85,505	81,745	2.83%	9,680	9,260	26	25
55 to 64	28,175	32,360	2.97%	4,185	4,800	12	13
65 and Older	29,725	34,615	4.00%	10,710	12,460	29	34
Overall	**143,405**	**148,720**		**24,575**	**26,520**	**67**	**72**

Notes: (1) At-Risk Patient Population" is based on the calculation of the prevalence rate of acute mental illness in the population times the total age cohort population.
(2) The estimated inpatients is the calculation of Percent At-Risk times Percentage appropriate for inpatient treatment. Inpatient rates based on cited Surgeon General's Report, NIMH.
(3) Based on lengths of stay of 4 days for 18 to 54, 5 days for and 55 to 64 and 9 days for 65 and older.

Source: U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999, pages 46 through 48.

Need for Organized Outpatient Services. The need for organized hospital-based outpatient program services is based on the Substance Abuse and Mental Health Services Administration's Office of Applied Statistics analysis of outpatient mental health services in the United States.[18] Exhibit Eight summarizes the potential volumes for organized outpatient psychiatric programs such as IOP services serving the primary market.

It is estimated that IOP services will be the most appropriate level of psychiatric intervention for approximately *1,070* general adults, older adults and geriatrics in the primary market. IOP services are a complimentary service usually provided as part of a range of inpatient and outpatient psychiatric services. Providing IOP services as part of a continuum of inpatient and outpatient services allows for the opportunity of shared staffing and provision of economy of scale operations.

[18] SAMHSA Office of Applied Statistics, Patterns of Mental Health Services Utilization and Substance Abuse Use Among Adults, 2000 and 2001. Chapter 4: Characteristics of Persons Receiving Outpatient Treatment, 2004.

Exhibit Eight. 2012 Estimated and 2017 Projected Need for Hospital-Based Organized Outpatient Behavioral Health Services, Westerly Market, by Age Cohort

Age Group	Population	IOP Patients	CD-IOP Patients	Private Therapist
2012 Estimate				
18 to 64 Years	113,680	795	780	1,290
65 Years or Older	29,725	275	195	505
Totals	**143,405**	**1,070**	**975**	**1.,795**
2017 Projection				
18 to 64 Years	114,105	835	785	1,390
65 Years or Older	34,615	315	230	590
Totals	**148,720**	**1,150**	**1,015**	**1,980**

Note: Private therapist includes psychiatrists, psychologists and mid-level clinicians.

It is estimated that CD-IOP services will be the most appropriate level of behavioral health intervention for approximately 975 general adult, older adult and geriatrics in the primary market in 2012 increasing to 1,015 patients by 2017.

Existing Psychiatric Resources. The closest inpatient programs to the primary market are located at Kent Hospital in Warwick and Newport Hospital in Newport which are located approximately twenty-five (25) miles from Westerly. The existing behavioral health services associated with Kent Hospital include a 20-bed general adult inpatient psychiatric unit and a 20-bed inpatient unit at Butler Hospital in Providence. In the aggregate these inpatient units experienced an FY 2009 ADC of 35.2 patients (88.1% occupancy) including a geriatric ADC of 0.9 patients. Newport Hospital's behavioral health services include a fifteen (15) bed general adult inpatient unit. In FY 2009, these beds experience an overall reported ADC of 10.9 patients (72.4% occupancy) including a geriatric ADC of 1.2 patients.

In addition to the issue of the proximity of the population to available inpatient services, is the additional question of the availability of resources themselves. The Exhibit Nine illustrates the high utilization of the existing psychiatric beds in Rhode Island.

Exhibit Nine. Utilization of RI Hospital Psychiatric Units, 2007 through 2009

Year	Beds	ADC	Occupancy
2007	326	299.7	91.9%
2008	336	305.2	90.8%
2009	356	310.5	87.2%
3-Year Average	***339***	***305.1***	***90.0%***

Source: Zimmerman, Table 7.

As indicated by the Exhibit, the existing inpatient psychiatric beds in RI are highly utilized. The high utilization of existing resources results in beds not being available when needed. The general unavailability of beds on demand is illustrated by an example from the RI statewide "bed board" report of available psychiatric beds. On April 30, 2012, it was reported that there were forty-three (43) patients waiting for placement in a psychiatric bed (27 adults and 16 minors). Six (6) of the forty-three (43) were in the South County Region[19]. *The addition of inpatient adult and geriatric beds at Westerly will specifically increase access and availability to needed inpatient and outpatient psychiatric services in the South County Region as well as in Rhode Island overall.*

Unmet need. The prevalence-based bed need assumes no barriers to access and includes patients receiving treatment in alternative settings. The primary "adjustments" to the prevalence–based methodology that account for patients receiving treatment in alternative setting or not able to access services are:

- *Individuals in nursing homes with a severe mental illness ("SMI").* In RI, the estimated percentage of nursing home patients with SMI was 25.0%. In CT, the estimated percentage of nursing home patients with SMI was 22.2%. Since the majority of patients in nursing homes are 55 years and older, this adjustment is applied only to the older adult and geriatric populations. The adjustment equates to a reduction in the older adult and geriatric beds of fourteen (14) older adult and geriatric beds.

[19] Five (5) of the patients awaiting placement were at Westerly Hospital.

- *Individuals in alternative custodial settings.* It is estimated that approximately 15% of individuals incarcerated in custodial settings have a severe mental illness that would otherwise warrant inpatient treatment. This adjustment is generally limited to a general adult population. The adjustment equates to a reduction in the general adult beds of four (4) beds in both 2012 and 2017.

The unmet need for inpatient general adult and older adult/geriatric beds, as adjusted is summarized in Exhibit Ten.

Exhibit Ten. Unmet Need for Inpatient Psychiatric Beds, Demand-Based and Prevalence-Based Methodologies, with Adjustments

Methodology	2012 Estimated					2017 Projected				
	Adult	Older Adult	Total General Adult	Geriatric	Total Beds	Adult	Older Adult	Total General Adult	Geriatric	Total Beds
Demand-Based										
Calculated Need	31	10	41	10	51	28	13	41	12	53
Adjustments	0	0	0	0	0	0	0	0	0	0
Net Need	***31***	***10***	***41***	***10***	***51***	***28***	***13***	***41***	***12***	***53***
Prevalence-Based										
Calculated Need	26	12	38	29	67	25	13	38	34	72
Adjustments	(4)	0	(4)	(17)	(21)	(4)	0	(4)	(18)	(22)
Net Need	***22***	***12***	***34***	***12***	***46***	***21***	***13***	***34***	***16***	***50***

There are no psychiatric beds located in the primary market area. As previously discussed, the nearest beds are located at Newport Hospital and Kent Hospital. These programs in the aggregate, are operating at 88% occupancy and have limited capacity to accept additional patients. Effectively, the *average adjusted unmet need*[20] for beds to serve the primary market is estimated to be:

- **2012:** Thirty-eight (38) general and older adult beds and eleven (11) geriatric beds; and
- **2017:** Thirty-eight (38) general and older adult beds and fourteen (14) geriatric beds

[20] The average of the unmet need for psychiatric beds using both the demand-based and adjusted prevalence-based methodologies.

The Need for Psychiatrist Services. Professional psychiatric resources meet a number of community needs. In hospital settings, psychiatrists are a source of psychiatric consultation services to the medical staff. Psychiatrists also provide the medical direction and support to organized hospital-based psychiatric programs, and assist the hospital in addressing the community's need for psychiatric services. It is recommended that Westerly secure the services of two (2) psychiatrists and appropriate back-up support (i.e., physician extender) to support the inpatient and IOP behavioral health services. It is recommended that one of the psychiatrists has a background in geropsychiatry.

Section V
Findings.

The Facility

- *Westerly is a 125-bed acute care hospital located in Westerly (Washington County), Rhode Island ("RI").*
- *Westerly is currently in receivership and is operated under the overall control of a State-appointed Magister.*
- *Westerly provides a medical, surgical, obstetrical, emergency, laboratory and rehabilitative services using state-of-the-art technology in an intimate, community hospital setting.*
- *Westerly does not currently provide inpatient or outpatient behavioral health services as part of their array of existing services.*
- *Westerly has one (1) psychiatrist with active staff privileges.*

Acute Care Services

- *In 2010, Westerly provided 17,663 days of inpatient acute care services to a total of 4,238 patients.*
- *Westerly served an acute care Medicare and Medicaid patient population which accounted for 47.6% and 1.6% of their 2010 total acute care patient days, respectively.*[21]

[21] Ibid.

The Market

- *The primary market for inpatient and outpatient behavioral health services is comprised of all or portions of Kent and Washington Counties in RI, and New London County in Connecticut ("CT"). The primary market is comprised of persons residing within a radius of approximately twenty-five (25) miles of Westerly in RI and CT.*
- *The total population of the primary market was 181,640 in 2012. The overall population is projected to increase by 3,285 1.8% to 184,925 by 2017.*
- *In 2012, approximately 85,505 (47.1%) of the residents in the primary market were 18 to 54 years old. The adult population is projected to decrease by approximately 4,205 persons (4.4%) to 81,745 (44.2% of the total population) by 2017.*
- *In 2012, approximately 57,900 (31.9%) of the residents in the primary market were 55 years or older. The older adult and geriatric population is projected to increase by approximately 9,075 (15.7%) to 66,975 (36.3% of the total population) by 2017.*

The Need for Inpatient Behavioral Health Beds in the Market

- *Based on applying the historical demand-based use rates for inpatient adult and geriatric psychiatric services to the estimated and projected primary market area populations results in an estimated 2012 need for forty-one (41) general adult and ten (10) geriatric beds, increasing to forty-one (41) general adult and twelve (12) geriatric beds by 2017.*[22]
- *The net adjusted need for adult, older adult and geriatric beds in the primary market in 2012 using the prevalence-based methodology is estimated to be thirty-four (34) general and older adult beds and twelve (12) geriatric beds. In 2017, the net adjusted bed need is thirty-four (34) general and older adult beds and sixteen (16) geriatric beds.*

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[22] A *demand-based* methodology is used by the State of RI to project need on a state-wide basis for certificate of need purposes. The RI methodology has use rates for two (2) age groups – adult (18 to 64 years) and geriatric (65 years or older). For a consistent comparison with the *prevalence-based* methodology, applying the adult demand rate to the 55 to 65 population (i.e., older adult) of the primary market area results in the following bed breakdown:

- A 2012 estimate of 31 general adult, 10 older adult and 10 geriatric beds.
- A 2017 projection of 28 general adult, 13 older adult and 12 geriatric beds.

- *There are no hospital-based providers of inpatient or outpatient psychiatric services located within the primary market. There are two (2) hospital-based psychiatric programs located adjacent to the primary market at Kent Hospital (40 beds) in Warwick, RI and Newport Hospital (15 beds) in Newport, RI.*
- *The average adjusted net unmet need[23] for general adult, older adult and geriatric psychiatric beds in the primary market is:*
  - *2012: Thirty-eight (38) general and older adult beds and eleven (11) geriatric beds; and*
  - *2017: Thirty-eight (38) general and older adult beds and fourteen (14) geriatric beds*

Need for Intensive Outpatient Program ("IOP") Psychiatric Services

- *It is estimated that IOP services will be the most appropriate level of psychiatric intervention for approximately 1,070 general adults, older adults and geriatrics in the primary market including 385 general adult patients and 685 older adult and geriatric patients.*

Need for Chemical Dependency Intensive Outpatient Program ("CD-IOP") Behavioral Health Services

- *It is estimated that CD-IOP services will be the most appropriate level of behavioral health intervention for approximately 1,115 adolescents, general adults, older adults and geriatrics in the primary market including 1,015 general adult patients over the age of 25.*

Recommendations.

- *Develop a fifteen (15) bed geriatric inpatient psychiatric unit.*
- *Develop ten (10) bed general adult inpatient unit having a shared central nursing station with the geriatric unit.*
- *Develop a geriatric IOP program.*
- *Develop a general adult IOP program.*
- *Develop an adult CD-IOP services as an extension of the IOP outpatient program services to the general adult population.*

[23] The net unmet need using both methodologies was averaged together for 2012 and 2017.

- *Secure the services of two (2) psychiatrists with appropriate back-up support to support the inpatient and outpatient behavioral health services. It is recommended that one (1) of the psychiatrists has a background in geropsychiatry.*
- *Develop an organized program of community education, outreach and referral development for the inpatient and outpatient behavioral health services.*
- *Develop consultation and liaison services to Westerly's emergency department and medical-surgical services, as well as to nursing homes and personal care facilities in the area for the inpatient and outpatient behavioral health services.*

Section VI

Considerations. Development of new services requires planning and implementation. A number of diverse requirements and considerations must be addressed during implementation of these programs. The requirements and considerations are in the following areas:

- Environment of care requirements for inpatient and outpatient services;
- Compliance with various regulatory, licensing and accreditation requirements; and
- Financial impact.

Environment of Care Considerations.

Inpatient Services.

A normal configuration for the ten (10) bed adult inpatient unit includes the following:

- Four (4) semi-private and two (2) private rooms with an appropriate number of handicapped accessible restrooms;
- One (1) seclusion room with handicapped accessible restroom;
- A central nurses station with restroom (shared with the geriatric unit);
- One (1) multi-purpose group activity area which can be used as a dining area/multipurpose room;
- One (1) group room;
- Storage areas including clean and soiled linen areas;
- An examination room;
- Clerical/charting area;

- A multi-use consultation office; and
- Office space for the Program Manager, Outreach Coordinator, Nurse Manager – General Adult Unit, Licensed Clinicians and Consulting Medical Director (General Adult).

A normal configuration for the fifteen (15) bed geriatric inpatient unit includes the following:

- Seven (7) semi-private and one (1) private rooms with an appropriate number of handicapped accessible restrooms;
- One (1) seclusion room with handicapped accessible restroom;
- A central nurses station with restroom (shared with the general adult unit);
- A dining area/multipurpose room;
- One (1) group room;
- Storage areas including clean and soiled linen areas;
- An examination room;
- Clerical/charting area;
- A multi-use consultation office; and
- Office space for the Nurse Manager- Geriatric Unit, Licensed Clinicians and Consulting Medical Director (Geriatric).

Outpatient Services. The IOP and CD-IOP services will require approximately 1,500 square feet of space. The IOP and CD-IOP services will utilize the same space at different times/days. The normal configuration for the two Programs (Adult IOP/CD-IOP and Geriatric IOP) includes the following:

- A Reception area;
- Two handicap accessible restrooms;
- Storage areas;
- Two large multi-purpose group activity areas;
- Clerical/charting area;
- Office space for the Program Director, Medical Director and Clinical staff; and
- A multi-use consultation office.

Third Party Compliance Considerations.

As with any new hospital-based program, numerous third party compliance reviews must be conducted in order for the program to become operational. Those reviews include the following:

- Certificate of Need ("CON"). The State of RI has a CON process. A certificate of need approval will be required for the proposed project.
- Licensure and Accreditation. Diamond can provide sufficient documentation in the form of policies and procedures necessary for the programs to meet the licensure requirements of the State of RI for the inpatient, IOP and CD-IOP services.
- CMS Distinct-Part Unit Certification. In order for new distinct-part psychiatric units to receive reimbursement under the Medicare Inpatient Prospective Payment System (IPPS) for Inpatient Psychiatric Facilities for services provided in the new beds, the hospital must obtain certification of the new beds as part of the Distinct Part Unit (DPU). The certification process requires submission of an 855-A application (which requires a $505.00 filing fee), as well as the receipt of CMS survey approval which includes completing the State licensing process. DPU certification for new beds can only occur at the beginning of a hospital's fiscal year. Westerly's fiscal year begins on October 1st.

Exhibit 5

The Health of Rhode Island Non-Metropolitan Communities

Office of Primary Care and Rural Health, November 2011

Introduction

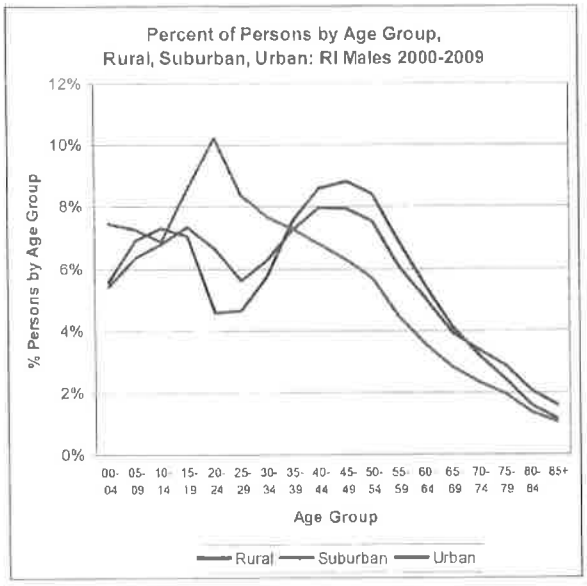
Rhode Island has 1,052,567 residents living in 39 cities and towns. Its five counties comprise 1,045 square miles and cover both metropolitan and non-metropolitan/rural areas.[1] The Rhode Island Office of Primary Care and Rural Health (OPCRH) has designated the following 16 cities and towns non-metropolitan areas:

- Providence County: Burrillville, Foster, Glocester, Scituate
- Kent County: Coventry, West Greenwich
- Washington County: Charlestown, Exeter, Hopkinton, New Shoreham, Richmond, Westerly
- Newport County: Jamestown, Little Compton, Portsmouth, Tiverton

More than 175,000 people, or 17% of the state's population, live in these communities.

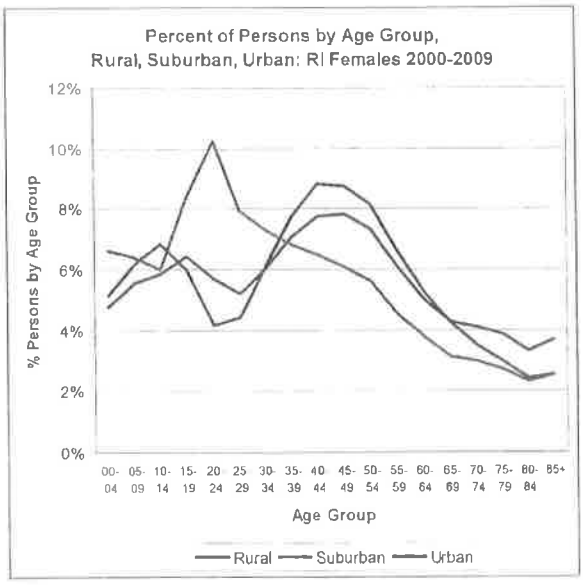
Metropolitan and Non-Metropolitan Areas of Rhode Island

It is important to note that the definition of "non-metro" established by the OPCRH differs from the federal definition of "rural." Using US Census data, the OPCRH designates all municipalities with a population density of 500 persons per square mile or less as "non-metro."[2] The Health Resources and Services Administration (HRSA) Office of Rural Health Policy classification is more narrowly defined; only the town of Westerly meets HRSA criteria for a rural community. Briefly, HRSA defines the following areas as rural: all counties designated non-metro by the US Census, all census tracts with RUCA codes 4-10 in metropolitan counties, or certain Census tracts (those with more than 400 square miles, fewer than 35 people per square Mile, and RUCA codes 2-3).[3]



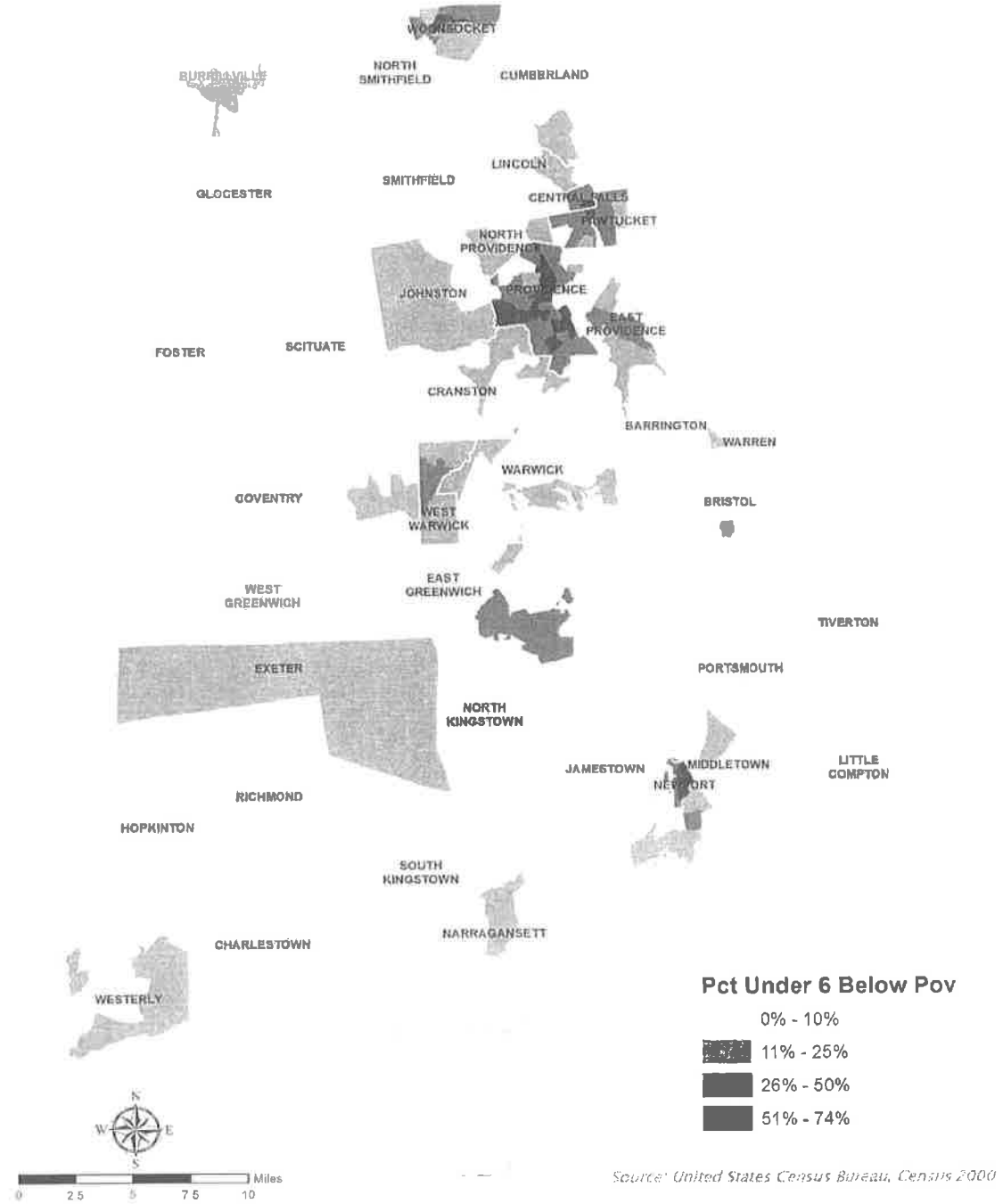
Demographic Information

The state population is predominantly white, non-Hispanic (76.4%).[4] Non-metro Rhode Island is less diverse, with people of white, non-Hispanic origin making up 94.7% of the population.[5] The non-metro population of Rhode Island is also older than the rest of the state with 15.3% of the population older than the age of 65. Comparatively, older adults make up 14.4% of the statewide and 13.0% of the national populations.[6]



According to the 2005-2009 US Census American Community Survey 5-Year Estimates, an average of 4.5% of people in non-metro communities in Rhode Island live below the federal poverty level, compared to 11.6% statewide.[7] Although the Providence area has the highest rates of child poverty, concentrations of poverty exist in the non-metro regions of Westerly, Exeter, Burrillville, and Coventry where

Percent of Children Younger than Six Living below Poverty, Census 2000



Rhode Island Non-Metro Health Data

Like the nation as a whole, Rhode Islanders continues to experience unacceptable disparities in health status, health outcomes, and access to healthcare across socio-economic, racial, ethnic and geographic lines. While an examination of health indicators demonstrates that Rhode Island non-metro populations are doing better than the rest of the state on a number of measures including rates of heart disease, diabetes, low birth weight, breastfeeding, and numbers of residents with insurance, a few key indicators show significant disparities between non-metro areas and the rest of the state. These include adolescent risk-taking behavior with non-metro high school students reporting rates of alcohol, drug and cigarette use that are significantly above suburban and urban communities. Other areas of concern include significantly lower participation in the Women, Infants, and Children (WIC) Program by eligible families. Residents of Rhode Island non-metro areas also face unique systems barriers including limited access to health providers, inadequate public transportation, and environmental health risks such as high levels of radon and lead in specific communities.

Outlined below are key data and information currently available for non-metro communities. This data has been compiled from a variety of sources including hospital discharge and death data collected by the Rhode Island Department of Health, the Behavioral Risk Factor Surveillance System survey, Rhode Island Kids Count, the Rhode Island Cancer Registry, the Rhode Island Department of Health Radon Database, and The Providence Plan. The data compare non-metro communities to suburban and urban communities. The non-metro communities consist of the 16 towns identified by the OPCRH, while the urban category includes the core cities of Providence, Pawtucket, Central Falls, Woonsocket, Newport, and West Warwick. The remainder of the state is considered suburban for the purposes of this report. This data is limited due to several statistical obstacles around analyzing small populations. Findings of community assessments conducted by non-metro partners augment this information and are described in a following section.

Adolescent Behavior

High school students living in non-metro communities report some of the highest alcohol, drug, and cigarette use in the state. According to the Rhode Island Department of Education, 51% of students in the Chariho and Westerly school districts and more than 45% of students in the

Burrillville, Foster-Glocester, Portsmouth, and Coventry school districts report having used alcohol at least once in the past 30 days. In contrast, 42% of students statewide and 37% in core cities report any use in the past 30 days.

Drug use in non-metro communities is also significantly higher than statewide and urban rates. Thirty-eight percent of Tiverton students and more than 35% of students from the Chariho and Foster-Glocester school districts report having used drugs in the past 30 days. The state rate for high school students reporting any drug use within the past 30 days is 27% and the rate for core cities is 22%.

Cigarette use by high school students in non-metro communities is also elevated. Thirty-four percent of high school students from Foster-Glocester, 29% from Coventry and Tiverton, 28% from Chariho and Westerly, and 27% from Burrillville report using cigarettes within the last 30 days. The state rate for cigarette use among high school students is 22% and the rate for core cities is 18%.[9]

Unintentional Injury

Death rates from unintentional injuries have traditionally been higher in rural populations when compared to urban regions. In New England alone, the accidental death rate in rural regions is nearly 50% higher than that in urban regions. Transportation-related deaths and deaths from firearm-related accidents are also notably higher.[10] However, in Rhode Island, we saw no statistical difference in the rates of death from unintentional injuries[11] between the three regions (19 in non-metro, 24 in suburban, and 17 in urban regions per 100,000 deaths).[12] This may be due to the relatively short transportation time for emergency medical services in Rhode Island. Although some deaths may be attributed to factors related to rural lifestyle and infrastructure, the amount of time it takes to transport a patient to medical facilities most likely contributes to the higher rual unintentional injury death rates in other states.[13]

Heart Disease

Deaths from cardiovascular disease are lower in non-metro communities (115 per 100,000 deaths) and core cities (108 per 100,000 deaths) than in the suburban region (171 per 100,000 deaths). Similarly, deaths from ischemia and other forms of heart disease are statistically higher

in the suburban region (137 per 100,000 deaths) than both the urban (85 per 100,000 deaths) and non-metro (97 per 100,000 deaths) regions.[14]

Cancer

Incidence rates of some of the most common forms of cancer including colorectal cancer (63 men and 46 women per 100,000), invasive lung cancer in women (61 per 100,000), and in situ breast cancer (38 per 100,000) are similar to rates for suburban and urban communities. Rates of invasive lung cancer in men (83 per 100,000) and prostate cancer (158 per 100,000) are lower than statewide averages (92 and 161 per 100,000, respectively). While the data reveals a slightly higher rate of invasive cervical cancer in women living in non-metro communities (8 per 100,000) than that of women living in suburban areas (7 per 100,000), the difference is not statistically significant.

Other Chronic Diseases

The available data on other chronic diseases suggest that non-metro communities are doing the same as, if not better than, the rest of the state. There are lower death rates from diabetes in the non-metro regions (7 per 100,000 deaths) when compared to suburban (11 per 100,000 deaths) and urban (10 per 100,000 deaths) regions. Hospital discharge data for incidents of asthma show elevated rates in the urban (212 per 100,000 people) and suburban regions (111 per 100,000 people), but lower rates in the non-metro region (88 per 100,000 people). Self-reported doctor-diagnosed obesity is highest in the core cities at 29% and lower in both the non-metro and suburban regions (25% for both). Deaths from stroke are also lowest in the non-metro regions (12 in non-metro, 26 in suburban, and 20 in urban regions per 100,000 deaths). Self-reported doctor-diagnosed high blood pressure shows no significant difference (30% non-metro, 30% sub-urban, 28% urban).[15]

Maternal and Child Health

There are statistically similar rates between non-metro and suburban regions for preterm births (11% in non-metro, 11% in suburban, and 13% in urban regions), low birth weight babies (7% in non-metro, 7% in suburban, and 9% in urban regions), and infant mortality (5 in non-metro, 5 in suburban, and 8 in urban regions per 1,000). In all categories, the highest rates were found in the urban region. Non-metro and suburban regions also have lower rates of delayed prenatal care

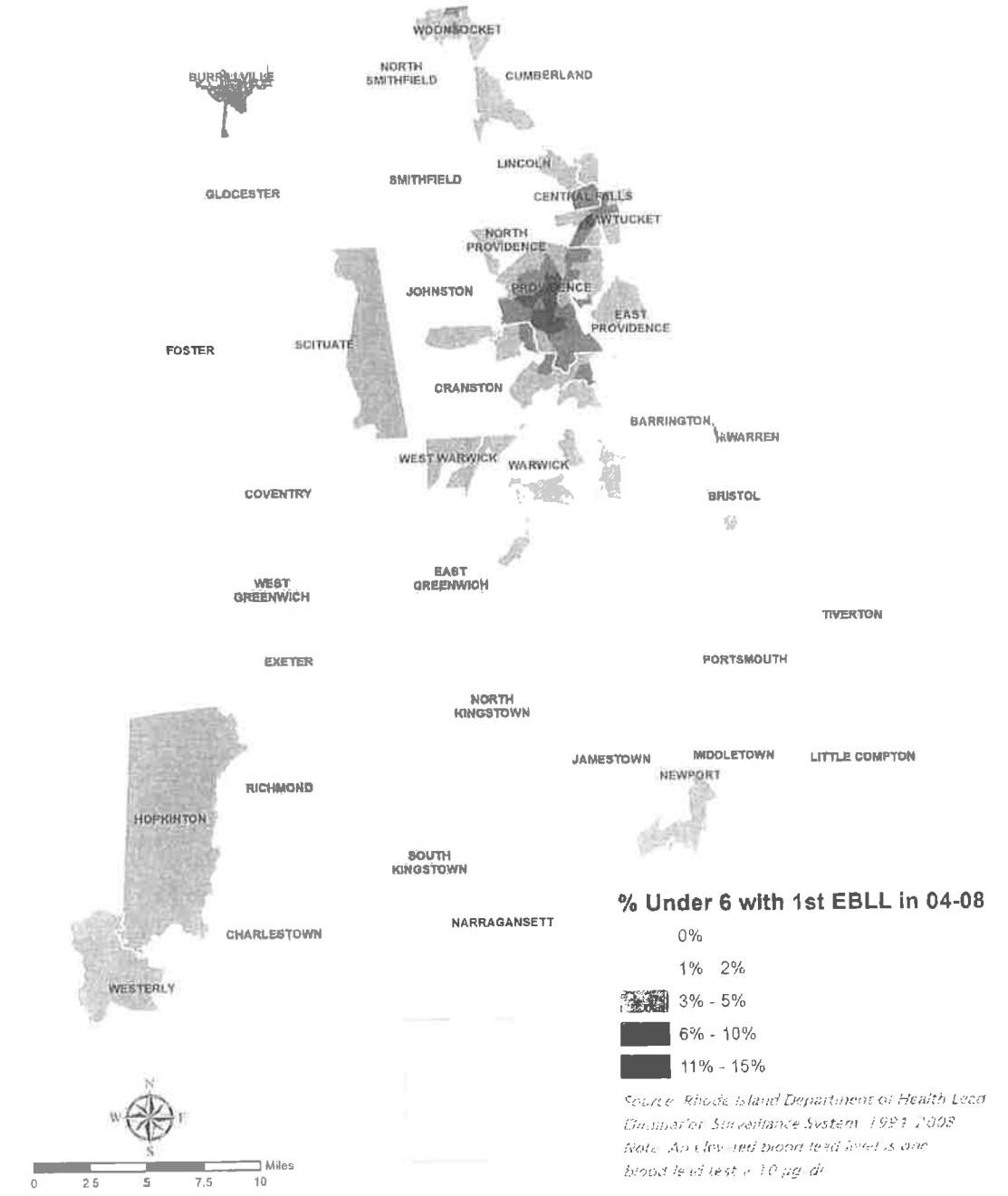
(10% in non-metro, 11% in suburban, and 19% in urban regions) and births to single mothers (30% in non-metro, 34% in suburban, and 62% in urban regions). Rates of breastfeeding[16] are also higher in the non-metro (69%) than in the urban (50%) regions.

However, there are significantly lower rates of WIC participation[17] in the non-metro communities (59.1%). According to Rhode Island Kids Count data, only 59% of women and children who are eligible for WIC actually participate in the non-metro regions. This is compared to 64% of eligible people in suburban regions and 76% in urban regions. Although the non-metro and suburban rates are not statistically different, they both differ significantly from both the urban and statewide (72%) rates, with participation lowest in the non-metro communities.[18] This finding is reflected in assessments carried out by our non-metro community partners, YWCA Northern Rhode Island and Northern Rhode Island Area Health Education Center, which will be discussed in a following section.[19]

Environmental Health Risks

Non-metropolitan Rhode Island residents must cope with specific environmental health challenges. The areas of greatest radon hazard in the state are in rural Washington County; the towns of Exeter and Richmond have shown more than 50% of tested homes to have high levels of radon gas. Four other municipalities in non-metro areas had more than 30% of homes test high for radon including Hopkinton and Charleston in Washington County; West Greenwich and Coventry in Kent County; and Foster and Scituate in Providence County.[20] Although the highest rates of elevated blood lead levels are found in Providence, there are some portions of non-metro Rhode Island that show increased rates. In the towns of Burrillville, Scituate, Hopkinton, and Westerly, 3% to 5% of the population younger than six years of age has elevated blood lead levels (as shown in the map below).[21]

Children Younger than Six with First-Time Elevated Blood Lead Levels (EBLL), 2004-2008



Source: Rhode Island Department of Health Lead Poisoning Surveillance System, 1997-2008

Note: An elevated blood lead level is one blood lead test ≥ 10 µg/dl

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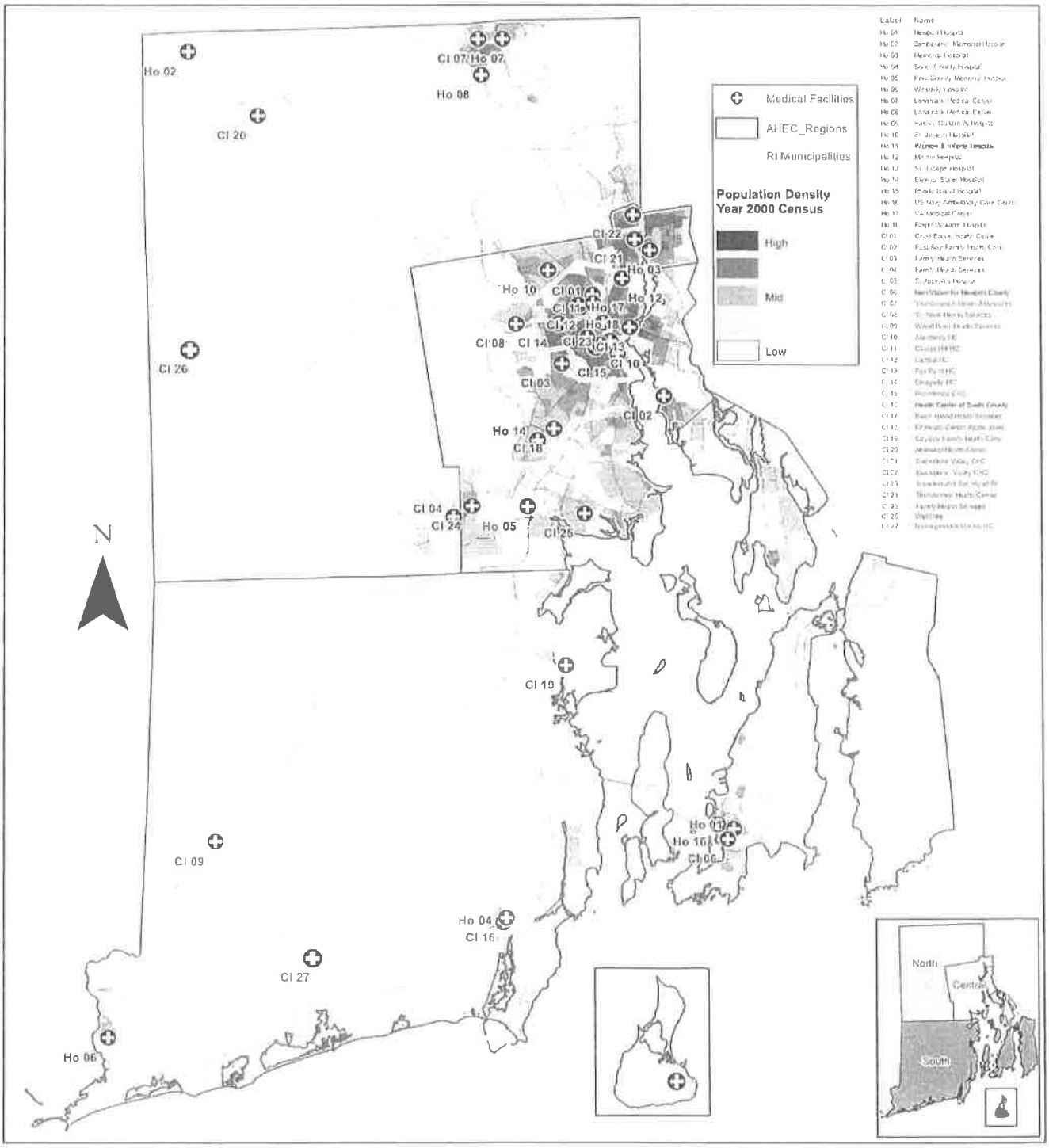
Non-Metro Health Systems Barriers

Access to Care

In rural communities throughout the US, low numbers of local healthcare providers and limited public transportation create barriers to accessing healthcare. In Rhode Island, a limited number of physicians practice outside the Greater Providence area. Moreover, the public transportation system is urban-oriented and inadequate for linking non-metro populations with the major medical centers in Providence and other urban areas. As shown in the first map below, non-metro Rhode Island has only seven medical facilities, which are found in the towns of Burrillville, Foster, Coventry, Hopkinton, Charlestown, and Westerly.[22] Similarly, as shown in the following two figures, far fewer physicians and dentists serve the non-metro regions. To request electronic copies of these maps for easier reading, please contact Mia Patriarca O'Flaherty at mia.patriarca@health.ri.gov

Rhode Island Medical Facilities and Population

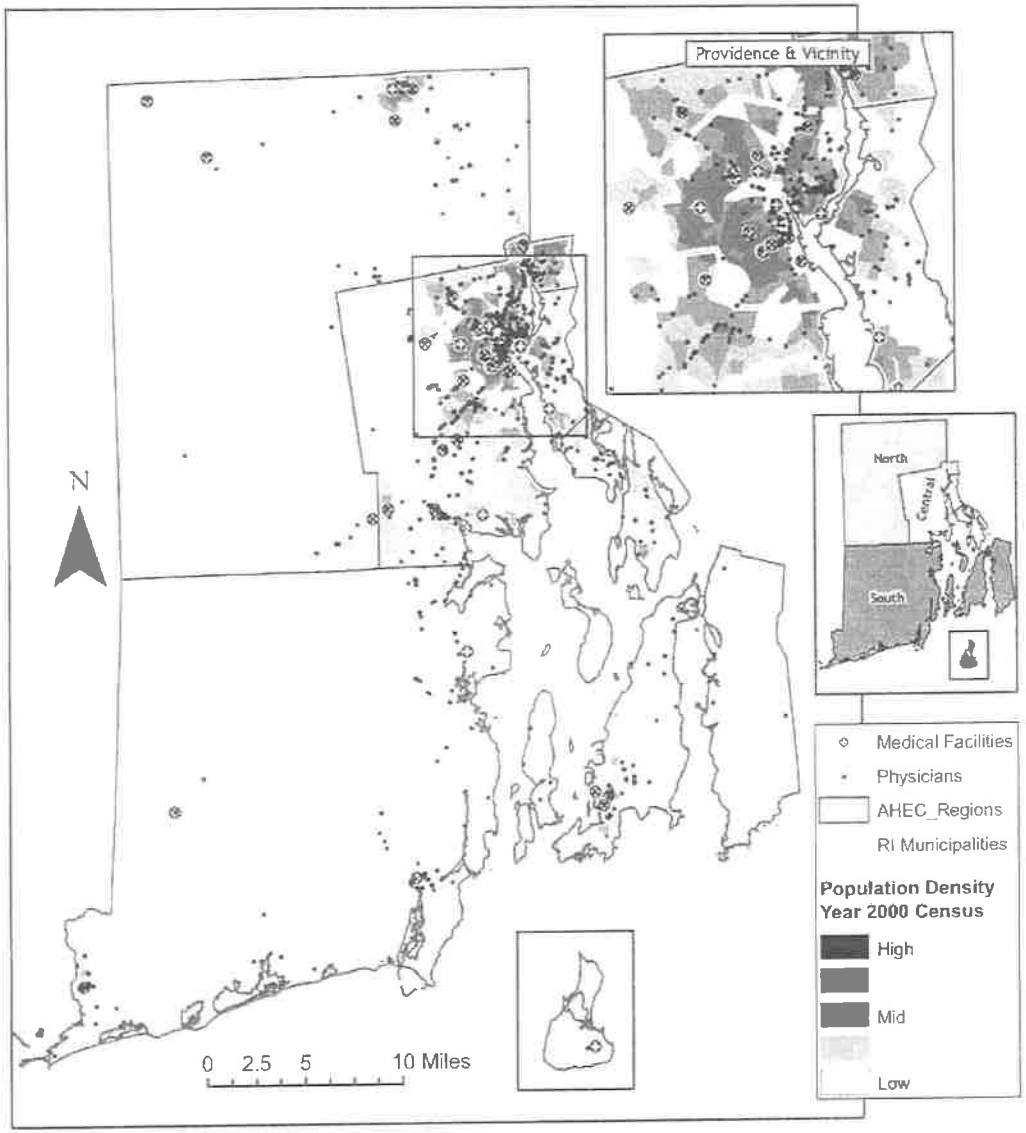


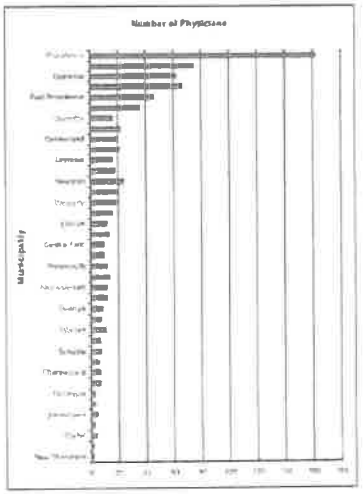
Rhode Island State Plane Feet, NAD83
Data Sources: City of Providence
Rhode Island Geographic Information System (RIGIS)

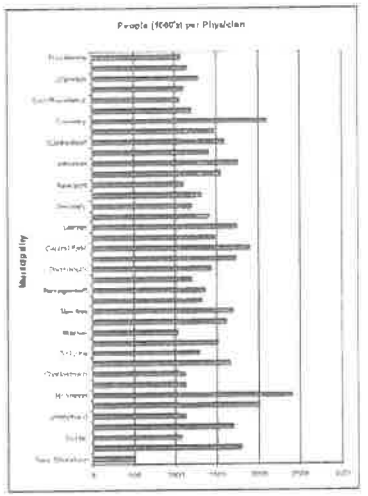
Map Produced by: The Providence Plan
For: The Rhode Island Area Health Education Program

Note: AHEC stands for Area Health Education Center.

Rhode Island Distribution of Physicians by Municipality





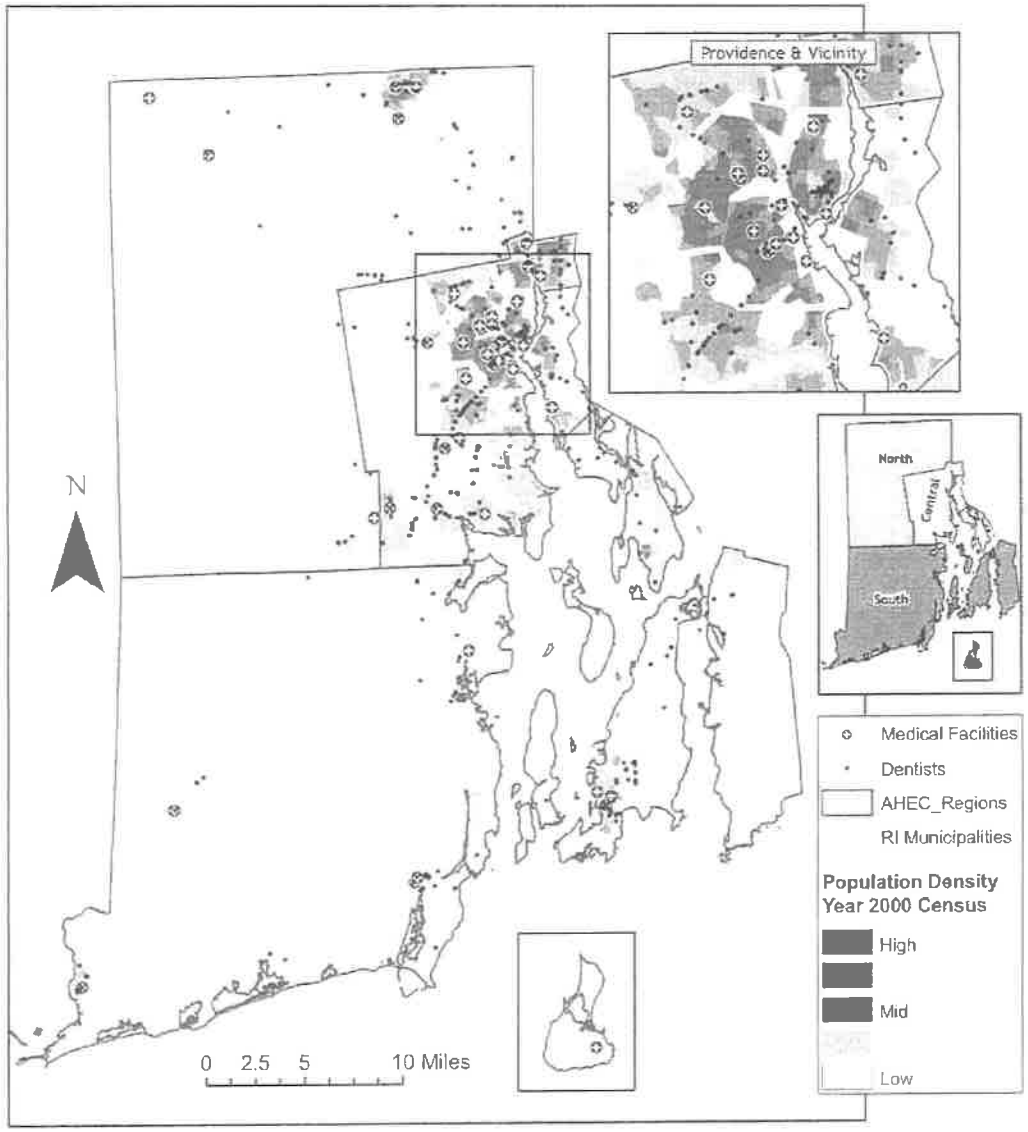


Rhode Island State Plane Feet, NAD83
Data Sources: City of Providence
Rhode Island Geographic Information System (RIGIS)

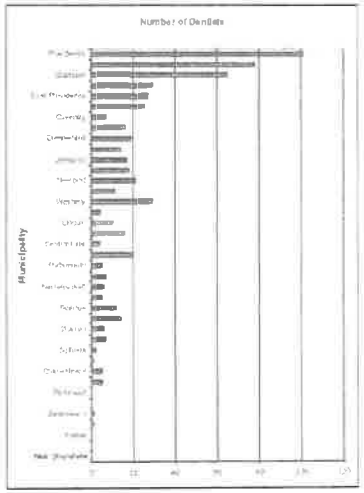
Map Produced by: The Providence Plan
For: The Rhode Island Area Health Education Program

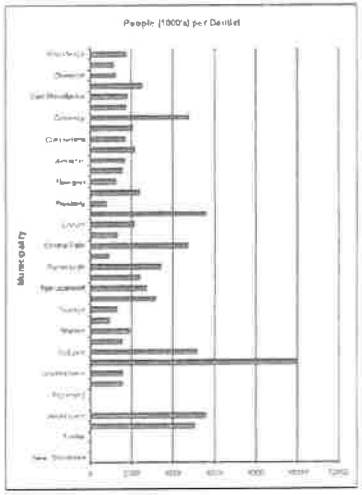
Note: AHEC stands for Area Health Education Center.

Rhode Island Distribution of Dentists by Municipality



Rhode Island State Plane Feet, NAD83
Data Sources: City of Providence
Rhode Island Geographic Information System (RIGIS)





Map Produced by: The Providence Plan
For: The Rhode Island Area Health Education Program

Note: AHEC stands for Area Health Education Center.

Healthcare Shortage Areas

Several federal programs in Rhode Island support healthcare provision to medically-underserved populations. These include 11 automatically-designated Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, and Indian Health Service-funded sites. Four of the FQHCs are either located in or serving Rhode Island's non-metro regions: Thundermist Healthcare, Wood River Health Services, WellOne, and the Comprehensive Community Action Program. Rhode Island also currently has designated six primary care Health Professional Shortage Areas (HPSAs), five Dental HPSAs, and four Mental Health HPSAs. The only HPSA located in the non-metro region is New Shoreham Town on Block Island.

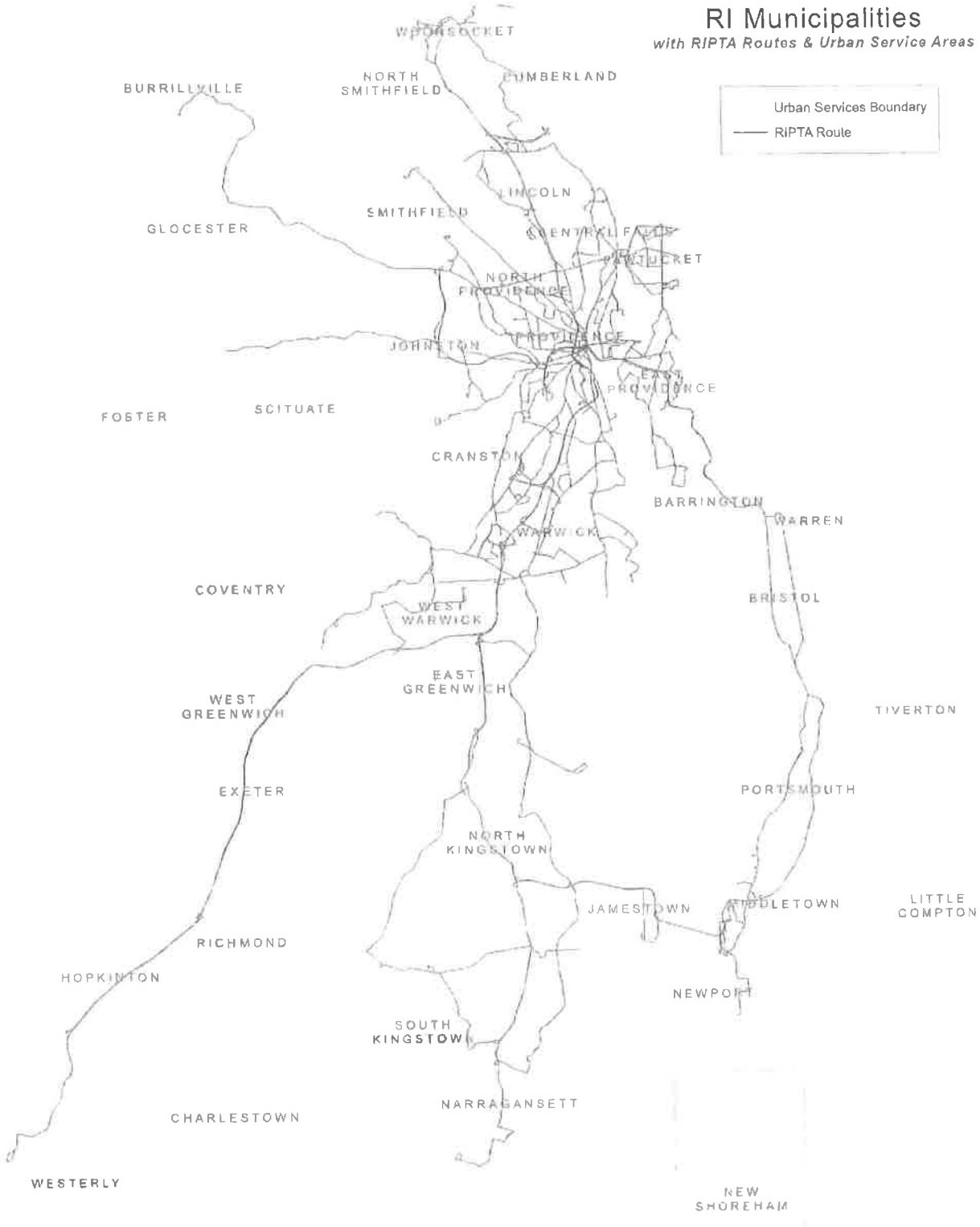
Insurance and Ongoing Sources of Care

According to Behavioral Risk Factor Surveillance System (BRFSS) data estimates,[23] non-metro regions have equal or higher rates of insurance and ongoing care when compared to urban or suburban regions. Core cities consistently show the lowest rates. In the non-metro region, 92% of respondents have health insurance. This is compared to rates of 93% in suburban Rhode Island and 83% in the urban region. Similarly, 92% of non-metro residents report having a regular provider, as compared to 88% in suburban, and 82% in urban Rhode Island.

Public Transportation

Lack of transportation is a consistent barrier to healthcare in rural communities throughout the United States. Even within New England, more than 1 in 20 households in the combined rural areas have no vehicle and no practical public transportation option.[24] As evident in the map below, most Rhode Island Public Transit Authority (RIPTA) bus routes exist within urban service boundaries. Most non-metro towns have only one RIPTA bus route through the area, while the towns of Foster and Charlestown have none.[25] In Rhode Island a few programs such as the Flex service and the RIde program have begun to address some of these barriers, but they are still do not adequately meet the need of many non-metro communities.

Rhode Island Public Transit Authority (RIPTA) Bus Routes



Rural Health Assessments

To support communities to begin to address non-metro health barriers outlined above, the OPCRH awarded eleven mini-grants between 2009 to 2011 to qualified community-based coalitions and networks in non-metro regions of the state. The mini-grants supported community assessments that expanded upon the often limited non-metro health data. Grantees were allowed to choose the scope of their projects. They were asked to conduct community assessments to identify gaps in healthcare services and delivery systems and to develop strategic plans to address these issues. Grantees included organizations from all four counties containing non-metro regions:

- Providence County: WellOne (Foster), Northern Rhode Island Area Health Education Center (nriAHEC), and YWCA Northern Rhode Island
- Kent County: Visiting Nurse Association (VNA) of Care New England (Coventry), Comprehensive Community Action Program (CCAP), Inc. (Coventry)
- Washington County: Washington County Children's Coalition (WCCC)
- Newport County: Visiting Nurse Services (VNS) of Newport and Bristol Counties

From the assessments, the OPCRH identified five major barriers to accessing healthcare in the non-metro regions:

1. Inadequate capacity of dental services
2. Insufficient supply of mental health services
3. Lack of knowledge of resources
4. Individual stigma around receiving services and benefits
5. Inadequate public transportation

Dental Services

As was shown in a previous figure, a limited number of dentists serve the non-metro regions. Several grantees identified inadequate supply of dental services as an area of high need. For example, VNA of Care New England identified routine dental care as the top unmet need for the senior population in Coventry.[26] CCAP identified a similar need in pediatric services in Coventry. According to the CCAP survey, 30% of families said that their children had not visited the dentist in the last year, while 51% of parents had not visited the dentist in the last year and 27% could not afford dental care.[27]

Mental Health Services

Several grantees identified mental health services as an area of need in non-metro communities. For instance, the WCCC identified access to children's mental health services as a primary issue in Washington County. In response, WCCC has designed and delivered training and support for medical clinicians and staff, children's behavioral health and social service providers, and school personnel. They have also developed plans for a social marketing campaign to prevent bullying among middle school students.[28] CCAP also found an insufficient supply of affordable mental health services for all ages in Coventry. An alarming six of eight (75% of) adults that needed mental health counseling had difficulty getting it.[29]

Knowledge of Resources and Stigma

In addition to a lack of resources, there are clear and real social barriers to accessing care. Often, people are unaware of the services for which they would qualify. Furthermore, while some are aware of the services available, they are unwilling to take advantage of these services due to a sense of stigma associated with receiving benefits. This is reflected in the lower rates of participation in WIC for eligible mothers and children and was also identified as an issue by our community partners' assessments. WellOne found that a lack of knowledge of benefits or a lack of knowledge of how to apply for such benefits often prevented residents from seeking help. Furthermore, individual attitudes toward receiving assistance prevented residents from seeking help.[30] The YWCA and nriAHEC found that participation rates in Burrillville, Foster, Glocester, and Scituate for the WIC program, the Supplemental Nutrition Assistance Program (SNAP), and the school breakfast program were all lower in comparison to state rates. YWCA and nriAHEC also hypothesized that the low WIC participation rates may not only be due to lack of knowledge of resources, but also to stigma attached to receiving such assistance.[31]

Public Transportation

Finally, as outlined in a previous section, non-metro areas face significant transportation barriers. Assessments by WellOne, CCAP, YWCA and nriAHEC all concluded that transportation issues are one of the biggest challenges facing non-metro residents. CCAP found that 22% of residents did not get needed care due to transportation.[32] Because of these issues around transportation and

accessing services, nriAHEC and YWCA proposed the use of social media methods to reach out to local young women to increase their knowledge base around women's health and wellness issues, food insecurity, and prenatal care.[33]

Rural Health Systems Building Grants

Building on the results of community assessments and recommendations developed under mini-grants, the OPCRH issued a request for proposals designed to strengthen primary care systems by working to develop healthcare infrastructure, increase access to healthcare, reduce health disparities between populations, and promote patient-centered medical homes. Special emphasis was placed on addressing the needs of the uninsured, the underinsured, minority populations, and children with special healthcare needs. Grantees were also required to address improvements in maternal and child health services as a part of their projects. The grants are for a two-year period, contingent on available funding and grantee performance. Eligibility was limited to non-profit organizations leading coalitions of primary care and community organizations serving non-metro regions of the state.

In October 2011, the OPCRH made two Rural Health Systems Building awards. These include a project led by YWCA Northern Rhode Island, in partnership with nriAHEC, to develop and implement a strategic plan to improve access to primary care services (including prenatal care), reduce high risk behaviors, address cultural barriers to care, and improve nutrition among young women (ages 12 to 25) living in northwestern Rhode Island. The YWCA project will include a particular focus on physical activity as an entry point to connect young women with other preventive services. A second award was made to the Washington County Coalition for Children (WCCC) to develop and implement a strategic plan for improving children's behavioral health services, increasing the knowledge and competency of the local workforce, engaging and supporting parents, and providing anti-bullying programs for children living in Washington County. The WCCC project builds on eight years of successful children's mental health program development in the southern region of the state.

Recommendations and Next Steps

Based on the findings of community assessments and analysis of non-metro health data, the OPCRH has developed the following recommendations:

- Address adolescent risk-taking behavior in non-metro communities, including alcohol, drug and cigarette use. Connect local efforts to statewide resources, including the RIDOH Tobacco Control and Adolescent Health Programs.
- Promote federal and local workforce development initiatives to increase primary care, mental health and dental provider supply in non-metro communities
- Utilize Community Health Workers (CHWs) in non-metro communities to help residents navigate the health and social service systems and enroll in services such as WIC. Link non-metro CHWs to training and support resources.
- Connect non-metro partners with existing initiatives that promote expansion of public transportation to ensure that the needs of non-metro communities are addressed, including Healthy Places by Design at HEALTH and Grow Smart RI.
- Collaborate with HEALTH's Healthy Homes and Environment programs to design comprehensive environmental risk reduction initiatives in non-metro communities.
- Provide training and technical assistance to local networks, including supporting communities to evaluate the effectiveness of rural health systems building projects.
- Establish an information clearinghouse around rural health policy including health care reform, best practices, grant opportunities, and federal funding.

Rhode Island Office of Primary Care and Rural Health

The Rhode Island Rural Health program is housed in HEALTH's Office of Primary Care and Rural Health (OPCRH), within the Health Disparities and Access to Care Team of the Division of Community, Family Health, and Equity (DCFHE). The OPCRH exists to promote access to comprehensive primary care for all state residents. Particular emphasis is placed on assuring access and improving health outcomes for the traditionally medically underserved, racial/ethnic minorities, low-income and uninsured individuals, and those facing geographic barriers. The OPCRH is responsible for assessing primary care capacity in Rhode Island, delineating low-income, geographic, and specialty-specific shortage areas, and developing plans to address those shortages. The OPCRH provides a rural health information clearinghouse, technical assistance and other support to rural health partners, program coordination, rural health policy leadership, and development, recruitment, and retention of a skilled rural health workforce.

Acknowledgments

The OPCRII would like to thank the following individuals for their invaluable contributions to this report:

- Rhode Island Department of Health Staff
    - Center for Health Data and Analysis: Sam Viner-Brown, Steve Sawyer, Don Perry, Yongwen Jiang, Kathy Taylor
    - Division of Community, Family Health, and Equity: Deb Pearlman, Jorge Baptista
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    - Center for Public Health Communication: Sophie O'Connell
- New England Rural Health RoundTable: Marion Pawlek
- The Providence Plan: Kim Pierson
- Community partners: nriAHEC, YWCA Northern RI, VNS of Newport and Bristol Counties, Washington County Coalition for Children
- Rhode Island Department of Education: Jan Mermin

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[1] State and County Quickfacts, US Census Bureau, http://quickfacts.census.gov/qfd/states/44000.html, Last Revised October 13, 2011, Accessed October 25, 2011

[2] The only exception is the town of Coventry, which has a population density of 564.87 persons per square mile. This was community included as non-metro due to its location between other non-metro towns and because two Coventry census tracts, representing 65% of the town's area, have very low population density.

[3] Definition of Rural, Health Resources and Services Administration, www.hrsa.gov/ruralhealth/policy/definition_of_rural.html, Accessed October 25, 2011.

The Office of Rural Health Policy uses two methods to determine geographic eligibility for its grant programs. All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural. Counties classified as MAs are still non-metropolitan and considered rural. The current list of MAs are available at www.census.gov/population/www/metroareas/metrodef.html. RI has no rural counties, and five rural Census tracts in Washington County, for the purposes of the Rural Health Outreach, Network Development, or Rural AED Grant Programs.

Due to the fact that entire counties are designated as metropolitan when, in fact, large parts of many counties may be rural in nature, the Office of Rural Health Policy sought an alternative method of looking at sub-county sections of these MAs. Rural Urban Commuting Area Codes (RUCAs) are a Census tract-based

classification scheme that utilizes the standard Bureau of Census urban area and place definitions in combination with commuting information to characterize all of the nation's Census tracts regarding their rural and urban status and relationships. RI has no Census tracts with RUCAs coded as rural.

[4] State and County Quickfacts, US Census Bureau, http://quickfacts.census.gov/qfd/states/44000.html, Last Revised October 13, 2011, Accessed October 25, 2011.

[5] Fact Finder, US Census Bureau,. http://factfinder2.census.gov/. Accessed November 8, 2011.

[6] Fact Finder, US Census Bureau. http://factfinder2.census.gov/ Accessed October 25, 2011.

[7] This number is an average of the percent of non-metro towns and cities population living below the FPL the 2005-2009 American Community Survey, U.S. Census Bureau, http://factfinder.census.gov/home/saff/main.html?_lang=en, Accessed October 21, 2011.

[8] 2000 US Census Data. Map created by Providence Plan. Providence, RI.

[9] 2008 Rhode Island Kids Count, Factbook (2008). Providence, RI: Rhode Island KIDS COUNT.

[10] New England Rural Health RoundTable. *Rural Data for Action.* West Lebanon, NH. New England Rural Health RoundTable.

[11] Unintentional injuries include such things as drowning, falling, fire/burn, machinery accidents, traffic or transport accidents, environmental, poisoning, suffocation.

[12] These rates are based on the available 2010 data from CHDA

[13] New England Rural Health RoundTable. *Rural Data for Action.* West Lebanon, NH. New England Rural Health RoundTable. Pg. 40

[14] Data was collected by the Center for Health Data and Analysis at the Rhode Island Department of Health. Rates were calculated by dividing the total number of incidences in each region (non-metro, sub-urban and urban) by the total populations for each region based on 2010 Census data and multiplying by 100,000.

[15] Self-reported rates are based on results from BRFSS.

[16] "Breastfeeding" is the percentage of newborn infants who are exclusively breastfed at the time of hospital discharge

[17] Women and children participating in WIC is the percentage of eligible women, infants and children enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). WIC is a federally-funded program that serves pregnant, postpartum and breastfeeding women, infants, and children under five years of age with household incomes below 185% of the federal poverty level. In addition, any individual who participates in SNAP (formerly the Food Stamp Program), RIte Care, Medicaid, or the Rhode Island Works Program or who is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is automatically income-eligible for WIC.

[18] Rhode Island Kids Count. *2011 Rhode Island Kids Kids Count Factbook.* Providence, RI: Rhode Island Kids Count.

[19] Rhode Island Kids Count. *2011 Rhode Island Kids Kids Count Factbook.* Providence, RI: Rhode Island Kids Count.

[20] Data represents 43,463 houses tested for radon. Rhode Island Department of Health Radon Database, *Healthy Housing Databook 2010.* Rhode Island Department of Health; December 2008

[21] Rhode Island Department of Health Lead Elimination Surveillance System. Map produced by Providence Plan. 2008

[22] US Census 2000. City of Providence, Rhode Island Geographic Information System. Map produced by Providence Plan.

[23] BRFSS is a survey of non-institutionalized Rhode Island resident adults over the age of 18 that have a landline phone. The sample data are weighted to be representative of the target population.

[24] New England Rural Health RoundTable. *Rural Data for Action.* Bow, NH. New England Rural Health RoundTable.

[25] Map produced by Providence Plan. Providence, RI. 2011.

[26] Comprehensive Community Action, Inc. *Rural Health Mini Grant, Coventry Access Survey Results Summary.* Cranston, RI. Comprehensive Community Action, Inc ; 2011.

[27] Comprehensive Community Action, Inc. *Rural Health Mini Grant, Coventry Access Survey Results Summary.* Cranston, RI. Comprehensive Community Action, Inc ; 2011.

[28] Washington County Coalition for Children. *2009 and 2011 Mini-Grant Reports*. Narragansett, RI: Washington County Coalition for Children; 2009, 2011

[29] Comprehensive Community Action, Inc. *Rural Health Mini Grant, Coventry Access Survey Results Summary.* Cranston, RI. Comprehensive Community Action, Inc ; 2011.

[30] WellOne. *2010 Rural Health Mini Grant* . Foster, RI: WellOne; 2010.

[31] YWCA of Northern Rhode Island & Northern Rhode Island Area Health Education Center. *Addressing Prenatal Care & Food Insecurity for Young Women Living in Rural Northwestern Rhode Island.* Woonsocket, RI: YWCA of Northern Rhode Island & Northern Rhode Island Area Health Education Center; 2011.

[32] Comprehensive Community Action, Inc. *Rural Health Mini Grant, Coventry Access Survey Results Summary.* Cranston, RI. Comprehensive Community Action, Inc ; 2011.

[33] YWCA of Northern Rhode Island & Northern Rhode Island Area Health Education Center. *Addressing Prenatal Care & Food Insecurity for Young Women Living in Rural Northwestern Rhode Island.* Woonsocket, RI: YWCA of Northern Rhode Island & Northern Rhode Island Area Health Education Center; 2011.

State of Rhode Island Language data:
(American Community Survey: 2005-2009, 5 year Estimates): Census.gov

Top languages:

RI population [Est]: 996,110
Spanish: 99,683
Speak English very well: 44,718
Of 99,683 Spanish speakers, 50% **n**(49,965) speak English less than very well.

Portuguese or Portuguese Creolo: 33,923
Speak English very well: 19,618
Of 33,923 Portuguese speakers, 42% **n**(19,618) speak English less than very well.

French (Patois, Cajun): 14,333
Speak English very well: 11,712
Of 14,333 French Patois, Cajun speakers, 18% **n**(2,621) speak English less than very well.

French (Creole): 5,243
Speak English very well: 3,301
Of 5,243 French Creole speakers, 37% **n**(1,942) speak English less than very well.

Chinese: 4,474
Speak English very well: 2,087
Of 4,474 Chinese speakers, 53% **n**(2,387) speak English less than very well.

Mon-Khmer: 4,302
Speak English very well: 2,379
Of 4,302 Mon-Khmer speakers, 44% **n**(1,923) speak English less than very well.

Laotian: 3,131
Speak English very well: 1507
Of 3,131 Laotian speakers, 36% **n**(1,624) speak English less than very well

***Significant language data*:**

African languages: 3,964
Speak English very well: 2,651
Of 3,964 African language speakers, 33% **n**(1,313) speak English less than very well

Arabic: 1,735
Speak English very well: 1,200
Of 1,735 Arabic speakers, 31% **n**(535) speak English less than very well

Tagalog: 1,960
Speak English very well: 1,172
Of 1,960 Tagalog speakers, 40% **n**(788) speak English less than very well

Korean: 1,420
Speak English very well: 656
Of 1,420 Korean speakers, 54% **n**(764) speak English less than very well

Language data-Cities in RI

(American Community Survey: 2005-2009, 5 year estimates): Census.gov

West Warwick (Kent County), population: 27,668 (Core City)
Spanish: 1,286
Speak English very well: 603
Of 1,286 Spanish speakers, 53% **n**(683) speak English less than very well.

Portuguese or Portuguese Creolo: 984
Speak English very well: 709
Of 984 Portuguese speakers, 30% **n**(275) speak English less than very well.

French (Patois, Cajun): 496
Speak English very well: 428
Of, 496 French Patois, Cajun speakers, 14% **n**(68) speak English less than very well.

Tagalog: 213
Speak English very well: 127
Of 213 Tagalog speakers, 42% **n**(89) speak English less than very well

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Warwick (Kent County), population: 81,071
Spanish: 1,337
Speak English very well: 905
Of 1,337 Spanish speakers, 32% **n**(432) speak English less than very well.

Newport City (Newport County), population: 23,158 (Core City)
Spanish: 698
Speak English very well: 432
Of 698 Spanish speakers, 38% **n**(266) speak English less than very well.

Other Asian Languages: 93
Speak English very well: 0
Of 93 other Asian language speakers, 100% **n**(93) speak English less than very well.

Central Falls (Providence County), population: 16,840 (Core City)
Spanish: 9,717
Speak English very well: 4,089
Of 9,717 Spanish speakers, 58% **n**(5628) speak English less than very well.

Portuguese or Portuguese Creolo: 1,607
Speak English very well: 881
Of 1,607 Portuguese speakers, 45% **n**(726) speak English less than very well.

Cranston (Providence County), population: 76,036
Spanish: 7,164
Speak English very well: 3,992
Of 7,164 Spanish speakers, 44% **n**(3,172) speak English less than very well.

Portuguese or Portuguese Creolo: 1,383
Speak English very well: 936
Of 1,383 Portuguese speakers, 32% **n**(447) speak English less than very well.

Armenian: 803
Speak English very well: 434
Of 803 Armenian speakers, 46% **n**(369) speak English less than very well.

Chinese: 927
Speak English very well: 216
Of 927 Chinese speakers, 77% **n**(711) speak English less than very well.

Pawtucket (Providence County), population: 67,192 (Core City)
Spanish: 9,962
Speak English very well: 4,978
Of 4,978 Spanish speakers, 50% **n**(4,984) speak English less than very well.

Portuguese or Portuguese Creolo: 7,792
Speak English very well: 4,364
Of 7,792 Portuguese speakers, 44% **n**(3,428) speak English less than very well.

African languages: 947
Speak English very well: 515
Of 515 African language speakers, 46% **n**(432) speak English less than very well.

Providence City (Providence County), population: 159,935 (Core City)
Spanish: 55,124
Speak English very well: 24,603
Of 55,124 Spanish speakers, 55% **n**(30521) speak English less than very well.

Portuguese or Portuguese Creolo: 2,725
Speak English very well: 1,676
Of 2,725 Portuguese Creolo speakers, 39% **n**(1,049) speak English less than very well.

Mon-Khmer: 3,117
Speak English very well: 1,690
Of 3,117 Mon-Khmer speakers, 46% **n**(1,427) speak English less than very well.

African languages: 2170
Speak English very well: 1507
Of 2170 African language speakers, 31% **n**(663) speak English less than very well.

Woonsocket City, (Providence County), population: 40,154 (Core City)
Spanish: 3,864
Speak English very well: 2,587
Of 3,864 Spanish speakers, 33% **n**(1,277) speak English less than very well.

Laotian: 1,157
Speak English very well: 459
Of 1,157 Laotian speakers, 60% **n**(698) speak English less than very well

French (Patois, Cajun): 2,932
Speak English very well: 2,309
Of 2,932 French Patois, Cajun speakers, 21% **n**(623) speak English less than very well.

Westerly town, (Washington County), population: 22,398
Chinese: 458
Speaks English very well: 145
Of 458 Chinese speakers, 68% **n**(313) speak English less than very well.

State Population Change by Race and Ethnicity, US Census 2000 & 2010

Since the State of Rhode Island has no local public health departments, the Department of Health coordinates the public health activities across the state. To enhance the coordination and management of large scale disease outbreaks, the Healthcare Service Region (HSR) Model was created. The HSR Model divided the state into 10 HSR, each led by an acute care hospital. Each HSR was created along municipal boundaries with approximately 100,000 people per HSR. This design allows for enhanced service provision to Rhode Island's increasingly diverse population.

Over the past 10 years, Rhode Island has seen major changes in the population demographics. These changes call for a mix of services that respond to the varying needs of the state's changing demographics (e.g., language assistance and culturally competent care). A 2010 Census Brief notes that there was a 31% increase in the racial/ethnic minority population in Rhode Island from the year 2000 to 2010. Below is a snapshot of the demographic changes that have occurred in Rhode Island by comparing recently released 2010 Census data to 2000 Census data.

Table 1. Rhode Island Population by Race and Ethnicity: 2000 and 2010

	Population		Change	
	2000	**2010**	**Number**	**Percent**
Hispanic or Latino	90,820	130,655	39,835	43.9
White, NH	858,433	803,685	-54,748	-6.4
Black, NH	41,922	51,560	9,638	23.0
Asian/Pacific Islander, NH	23,736	30,293	6,557	27.6
Native American, NH	4,181	4,020	-161	-3.9
State Overall:	1,048,319	1,052,567	4,248	0.4

Approximately 21% of the population of RI is a racial or ethnic minority, according to the 2010 Census results. As noted in the table, the Hispanic population is the fastest growing population in Rhode Island, followed by the Asians and Pacific Islanders. The populations that have decreased over the last decade are non-Hispanic Whites and Native Americans.

Table 2. Our Lady Fatima Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	2036	4709	2673	56.8
White, NH	86929	84393	-2536	-2.9
Black, NH	1242	2392	1150	92.6
Asian/Pacific Islander, NH	1133	1688	555	49.0
Native American, NH	132	193	61	31.6
HSR Overall:	91167	92023	856	0.9

Table 3. Kent Hospital Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	2827	5309	2482	87.8
White, NH	159645	155219	-4426	-2.8
Black, NH	1558	2405	847	54.4
Asian/Pacific Islander, NH	2273	3417	1144	50.3
Native American, NH	388	437	49	12.6
HSR Overall:	167090	166158	-932	-0.6

Table 4. Landmark Medical Center Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	4212	6387	2175	51.6
White, NH	61944	59068	-2876	-4.6
Black, NH	1999	2764	765	38.3
Asian/Pacific Islander, NH	1862	2441	579	31.1
Native American, NH	192	228	36	15.8
HSR Overall:	69638	69108	-530	0.8

Table 5. Memorial Hospital Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	20192	28085	7893	39.1
White, NH	116594	108011	-8583	-7.4
Black, NH	6791	12324	5533	81.5
Asian/Pacific Islander, NH	1439	2651	1212	84.2
Native American, NH	366	748	382	104.4
HSR Overall:	144624	145135	511	0.4

Table 6. Miriam Hospital Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	1494	2902	1408	94.2
White, NH	91145	87277	-3868	-4.2
Black, NH	2794	3107	2006	71.8
Asian/Pacific Islander, NH	1101	1443	342	31.0
Native American, NH	307	336	29	9.4
HSR Overall:	99336	96912	-2424	-2.4

Table 7. Newport Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	2359	3512	1153	48.9
White, NH	78136	74729	-3413	-4.4
Black, NH	3184	2864	-320	-10.1
Asian/Pacific Islander, NH	1110	1351	241	21.7
Native American, NH	365	315	-50	-13.7
HSR Overall:	85433	82888	-2545	-3.1

Table 8. Rhode Island Hospital Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	52146	67835	15689	30.1
White, NH	94666	88623	-6043	-6.4
Black, NH	25243	28557	3314	13.1
Asian/Pacific Islander, NH	10432	11602	1170	11.2
Native American, NH	1975	2412	437	22.1
HSR Overall:	173618	178042	4424	2.5

Table 9. Roger Williams Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	3724	8890	5166	138.7
White, NH	84991	80413	-4578	-5.4
Black, NH	2965	4294	1329	44.8
Asian/Pacific Islander, NH	2724	4320	1596	58.6
Native American, NH	253	286	33	13.0
HSR Overall:	93867	95322	1465	1.6

Table 10. South County Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	1328	2069	741	55.8
White, NH	79144	81679	2535	3.2
Black, NH	884	1179	295	33.4
Asian/Pacific Islander, NH	1339	1409	70	5.2
Native American, NH	844	721	-123	-14.6
HSR Overall:	83875	87126	3251	3.9

Table 11. Westerly Population by Race and Ethnicity: 2000 and 2010				
	Population		Change	
	2000	2010	Number	Percent
Hispanic or Latino	657	957	300	45.6
White, NH	54733	37457	-17276	31.6
Black, NH	393	303	-90	-22.9
Asian/Pacific Islander, NH	973	689	-284	-29.2
Native American, NH	396	382	-14	-3.5
HSR Overall:	57353	39853	-17500	-30.5

Exhibit 6

#9

The Westerly Hospital

Charity Care/Financial Assistance	☐New X Revised	Page 1 of 4
	Revision/Effective Date: 10/01/2011	Supersedes: 10/98, 10/02, 3/06, 6/07, 7/11
Owner: Donna Duarte, Director Revenue Cycle **SEARCH TERMS:** Free Care		

Policy:

The Westerly Hospital offers financial assistance to patients without insurance or those that may be under insured. These services include payment plans, discount programs and prompt pay discounts. The Westerly Hospital also provides essential hospital care without charge to the uninsured with incomes up to 200% of the Federal Poverty Limits (and limited assets), and discounted care for incomes between 200% and 300% of the Federal Poverty Limits.

- The hospital shall make an initial determination of eligibility for any eligible assistance programs available. The hospital may refer the applicant to the appropriate medical assistance program.
- The availability of Financial Assistance is communicated by mail (bill definition/information) to all patients and by staff communication via phone and/or direct personal contact.
- Financial Assistance covers all hospital and hospital employed physician services for medically necessary services.
- Non residents, as defined as those outside the hospital demographic service area, will be eligible for free care or reduced cost services for all emergency services if they qualify for the hospital's free care guidelines.
- Whenever an application if given to a patient all eligible accounts will be put on a **free care pending** hold until the application process is complete.
- An applicant will be given 10 days to return application and a one time request for backup information if not provided with initial submission. If not received then the application will be filed as incomplete.
- Availability of Charity Care will be communicated to patients on a public notice basis. The Patient Accounting Financial Services Department will advise patients concerning their eligibility for the public assistance program before completing the application for Charity Care.
- Residents of foreign countries may be eligible for Charity Care only during emergency visits based on eligibility of Medicaid.

Scope:

This policy applies to all patients of The Westerly Hospital.

Purpose:

To provide financial assistance to patients without insurance or those that may be under insured.

Definitions:

Financial assistance is defined as any patients that do not have insurance or are under insured.

Procedure:

Patients may apply for financial assistance by filling out a Financial Aid Application. A patient, guarantor, relative or legal guardian may make the application. The Hospital will provide assistance to patients ineligible for state, federal or employer sponsored health insurance. Patients are required, based on eligibility, to apply for other government medical assistance before the Hospital will grant Charity Care.

- Verification of Income:
  1. The hospital will require proof of income which includes the following items: Federal Income Tax returns, W-2 forms, pay check stubs, a letter from an employer or accountant stating the applicants income, a statement of the gross benefit amount from any governmental agency providing benefits to the applicant, a copy of the most recent checking and savings statements.
  2. The hospital as an eligibility requirement may request the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and is within the applicant's ability to supply.
- Applicants may request financial aid for hospital services rendered up to 6 months from the date of service.
- An approved application will cover dates of service six months prior and 6 months forward from the date of application. For example, an approval application dated 01/11/2011 will consider dates of service 7/1/2010 through 7/1/2011 for financial assistance adjustment.
- An application for financial aid may be made every six months.
- An applicant who is responsible for complying for his/her insurers pre-certification requirements shall not be determined to be eligible for financial aid if he/she did not comply with the requirements of his carrier.
- The applicant shall cooperate by providing and verifying all information necessary to establish their eligibility. Applicants who fail to cooperate shall not be granted financial aid and will be responsible for all hospital charges.
- All applications will be reviewed by a team and then by the Patient Accounting Manager to determine eligibility.
- Asset determination: Assets are items that are or can be readily converted into cash or equity that can be borrowed against. This includes but is not limited to cash, savings, and checking accounts, certificates of deposit, treasury bills, corporate stocks and bonds, and trust funds.
  1. Motor vehicles: A third vehicle will be considered a full face value asset in a two adult family application. A secondary vehicle will be considered a full face value asset in an individual application.
  2. Home equity: A home owned as residence is not considered. Land or other property will be considered.
  3. Income: The applicant must provide proof of actual gross income for the previous tax year(form 1040) as well as current income.
- Assets and income will be combined and be compared to the most recent Federal Poverty Level Guidelines.

1. A person whose individual or if applicable family income is less than or equal to 200% of the poverty guidelines will receive full coverage financial aid.
2. A person who's individual or if applicable family income is greater than 200% but less than 300% will receive partial coverage based on the following sliding scale.

2011 HHS Poverty Guidelines

Persons In Family	48 Contiguous States and D.C.	48 Contiguous States and D.C. X2	Alaska	Hawaii
1	$10,890	$21,780	$13,600	$12,540
2	14,710	29,420	18,380	16,930
3	18,530	37,060	23,160	21,320
4	22,350	44,700	27,940	25,710
5	26,170	52,340	32,720	30,100
6	29,990	59,800	37,500	34,490
7	33,810	67,620	42,280	38,880
8	37,630	75,260	47,060	43,270
For each additional Person, add	3,820	7,640	4,780	4,390

3. Applicant will have 21 days to contact us to finalize payment plan arrangements. Failure to do so will result in a non-compliance denial.

- Litigation cases: The Patient Accounting Manager may make the final determination as to the implications of litigation accounts.
- Exception cases: The Patient Accounting Director may make the final decision on an as needed basis for deductibles, co-pays or out of pocket expenses.
- The hospital will provide each applicant with an approval or denial letter at the end of the process.

Appeals Process

- All applicants who have been denied have the right to appeal.
- Applicants who have been denied financial assistance who wish to appeal must send a letter in writing to the Financial Services Department and include the basis for the appeal and any additional supporting documentation.
- All appeals are reviewed by the Patient Financial Services Review Team and the Patient Accounting Manager.

Approvals:

Charles Kinney
President/CEO

Donna Duarte
Revenue Cycle Director

October 1, 1998
Reviewed October 1, 2002
Updated 3/2/06
Updated 6/7/07
Updated 7/1/2011
Updated 9/12/2011

THE WESTERLY HOSPITAL

APPLICATION FOR HOSPITAL FINANCIAL ASSISTANCE

(Any approval of this request is temporary and expires 6 months from the date of approval)

THE WESTERLY HOSPITAL	Date:
Patient	Guarantor
Date of Birth	Social Security # (if issued)
Social Security # (if issued)	Home phone
Home phone	Work/ Cell phone
Work / Cell phone	Relation to patient
Home address	Address
Occupation and employer	
Employer address	

Providing the information below on the patient's primary language, race & ethnicity is optional to the patient.

Language	English	Non-English
Ethnicity	Hispanic	Non-Hispanic
Race	Asian	American Indian / Alaskan Native
	Black / African American	Native Hawaiian / Pacific Islander
	White	Other or Multiple Races

Please provide the following information for ALLO members of the family unit, EXCEPT the Patient or Guarantor

Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address
Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address
Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address
Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address
Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address
Name & Relationship to Patient	SS# (if issued) & Date of Birth
Employer, phone & address	Home address

MONTHLY INCOME	ASSETS
Patient's salary & wages	Savings
Spouse's salary & wages	Checking
Gurantor's salary & wages	Certificates of deposit (CDs)
Self-employment income	Money Market Accounts
Child Care income	Savings bonds
Rental income	Stocks
Unemployment Compensation	Bonds
Temporary disability insurance	Mutual funds
Child support	IRSs
Alimony	401(k)s
Worker's Compensation	403(b)s
VA benefits	457s
Social Security payments	Cash-In value life insurance
Dividend & Interest income	Personal property
Royalties	2nd home & rental property
Pensions	2nd motor vehicle
Public Assistance	TOTAL
Other	
MONTHLY INCOME	
ANNUAL INCOME	

"I request the hospital to make a determination of eligibility for financial assistance. I understand that this information is confidential and subject to verfication by the hospital. I also understand that if the information I provide is false, I may be denied financial assistance and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Signature (patient/ guarantor)	Date

☐ APPROVED ☐ DENIED	
Hospital Authorized Signature	Date
APPROVED DISCOUNT (%)	APPROVED DISCOUNT ($)

Exhibit 7

Schedule 19

Payor Mix	Combined			Hospital Current			GeriPsych Only		
	Projected Utilization		Total Net Revenue	Projected Utilization		Total Net Revenue	Projected Utilization		Total Net Revenue
Inpatient	#	%		#	%		#	%	
Medicare	13,657	68%	20,872,714	10,646	66%	18,132,528	3,011	75%	2,740,186
RI Medicaid	1,184	6%	1,798,233	838	5%	1,567,894	346	9%	230,340
Non RI Medicaid	265	1%	478,177	209	1%	440,849	56	1%	37,327
Rite Care	6	0%	16,356	6	0%	16,356		0%	
Blue Cross	2,378	12%	6,239,378	2,085	13%	5,937,745	293	7%	301,633
Commercial	762	4%	1,452,622	678	4%	1,368,976	84	2%	83,646
HMO	1,432	7%	3,855,898	1,307	8%	3,730,429	125	3%	125,469
Self Pay/charity	512	3%	1,623,915	412	3%	1,615,042	100	2%	8,873
Other	-	0%			0%			0%	
Total	20,196	100%	36,337,293	16,181	100%	32,809,819	4,015	100%	3,527,474
Outpatient	#	%		#	%		#	%	
Medicare	62,846	38%	12,553,722	60,821	38%	12,233,625	2,025	90%	320,097
RI Medicaid	10,531	6%	2,627,990	10,531	7%	2,627,990		0%	
Non RI Medicaid	886	1%	398,114	886	1%	398,114		0%	
Rite Care	6	0%	6	6	0%	6		0%	
Blue Cross	42,573	26%	15,211,915	42,573	26%	15,211,915		0%	
Commercial	12,235	7%	4,365,201	12,235	8%	4,365,201		0%	
HMO	28,055	17%	11,644,164	27,830	17%	11,603,713	225	10%	40,451
Self Pay/charity	6,700	4%	4,146,617	6,700	4%	4,146,617		0%	
Other	-	0%			0%			0%	
Total	163,832	100%	50,947,729	161,582	100%	50,587,181	2,250	100%	360,548
			87,285,022			83,397,000			3,888,022

Exhibit 8

WORKING DRAFT

THE WESTERLY HOSPITAL
MEDICAL STAFF DEVELOPMENT PLAN

APRIL 2012

It is a given that physicians, both Primary Care (PCP) and Specialists, are the basis for a successful health care system. For this document, a PCP is defined as an Internist (IM), Family Physician (FP) or Pediatrician. PCPs are the drivers of inpatient admissions, referrals to specialists, and ancillary usage. Without a sufficient number to meet the community need, the health care system will never flourish.

For some time, there has been an insufficient number of physicians, both PCPs as well as specialists, to care for the Greater Westerly communities. The shortage of both PCPs and specialists has resulted in stagnant inpatient growth, referrals leaving town, slow growth in ancillaries and specialty referrals.

Like other RI hospitals, we had experienced difficulty in recruiting new physicians and retaining existing ones. The barriers identified from discussions with physicians include the lower reimbursement for physicians in Rhode Island, compared to Connecticut, and the high cost of living, notably in housing.

In 2006, the hospital, in conjunction with the medical staff, prepared an initial Medical Staff Development Plan. This was later adopted by the Board of Trustees. Because specialists tend to practice in close proximity to the hospital and PCP's tend to be in the local community, we are identifying the location for new PCP's by community. This recruitment plan has been and will continue to be updated on a periodic basis to adjust for any changes in staffing.

Atlantic Medical Group (AMG) was formed as a Rhode Island not-for-profit corporation to be the vehicle for recruiting new physicians. As a result, we have had considerable success in recruiting new physicians to the community.

Need for Physicians

The analysis of the need for physicians is a community based approach, with a multi-step process.

The ratio based approach is the most prevalent type of analysis in use today. There are a number of sources one can use for the physician to population ratios. While they all have advantages, there are significant limitations to solely using this approach. Therefore, when these are reviewed, one must be cognizant of these limitations and recognize that the projections for need are not absolutes, but are directional.

The Graduate Medical Education National Advisory Council (GMENAC) is the first source for physician to population ratios. GMENAC numbers for primary care physicians were updated in 1996. They were developed as a population based model, which has its own inherent problems, but is a very useful starting point. The numbers for specialists were last updated in 1990.

The second source is from an article written in 1993 by Kronick et al., "*The Marketplace for Healthcare Reform.*" This was written to describe need in large urban populations and is not truly compatible with smaller markets. It relied heavily upon recommendations from the GMENAC.

Nathan Kaufman in the October 2005 Trustee magazine is a third source for analysis.

All three models have the same limitations. They have not been updated for a number of years to reflect the changes in medicine, technology, and the needs / wants of the new generation of physicians. In general, many primary care physicians are seeking a different life style from prior generations of physicians. They are seeking to work fewer hours and have limited to no inpatient responsibilities.

The GMENAC (from which the others are based) was determined using the US population in 1980. They have not been adjusted to reflect either the national or local age distribution. In 1980, the US population between 45 and 64 years of age was 19.6% and was 11.3% for those over 65 years of age. Currently in the Westerly service area the numbers are 27% between 45 and 64 years, and 15% over 65 years. This is important because the use rates for health care services and physician services increases with age.

Those individuals between 45 and 65 use services 40% more than their younger counterparts, and those over 65 use them 500+% more than their younger counterparts. Therefore, those specialties which deal more with the middle age and older populations need to be adjusted up to reflect this fact.

When one reviews the current "supply" of physicians there are two modifying factors: 1) not all physicians wish to have full practices – need to estimate FTEs not bodies and 2) anecdotal evidence suggest that physicians begin to wind down their practices after age 60, warranting a succession plan as part of this analysis.

PCPs will become more difficult to obtain in the future as fewer candidates choose primary care compared to the more lucrative specialties. Specialists enjoy fewer hours and higher salaries than PCPs. Recently a number of residency programs reported many unfilled PCP slots.

One other limitation to the analysis is that communities are not isolated models. There is significant in-migration and out-migration in any community. Patients tend to remain in their local community (15 - 20 minutes) for primary care, but will travel further for secondary care and significantly further for tertiary care. The increase in the number of summer residents also has some impact upon the need for PCPs, which is not included in this analysis.

Table 1 reviews the three ratios discussed above. It also includes the suggested ratio for TWH, factoring in the limits of the above ratios. The latest population data we could find is from the Chambers of Commerce.

The population in the primary service area (Westerly, Charlestown, Richmond, Hopkinton, Stonington (Pawcatuck, Mystic) and North Stonington) is 70,626. **Table 2** compares the ratio to population analysis for each of the specialties. Specialists tend to locate their offices adjacent to the hospital but often times have a satellite office in the surrounding communities i.e. Mystic. Therefore, the specialist analysis is calculated on a service area basis. PCPs, however, tend to be located in the local communities. It should be noted that the population is significantly lower in all of the communities than the 2006 population estimates. These were forecasts from the 2000 census. This impacts the following tables. **Table 3** identifies the PCP need for each of the communities

The second step of the analysis reviews those physicians, who are potentially nearing retirement. We have identified physicians who are 60+ years of age, for whom we should begin to consider the potential for retirement over the next few years. **Table 4** identifies physicians by age who we should begin succession planning.

The third step includes a review of the physicians on our staff as a percentage of the physicians in practice in each community.

Table 5 is an updated (2009) version identifying both PCPs and specialists needed, a recruitment timetable, and proposed locations for new PCPs.

Appendix 1 is a list of the PCP (FP/IM) identified in our service area, which we used in the analysis.

TABLE 1

PHYSICIAN TO 100,000 POPULATION ANALYSIS

Specialty	Kronick	GMENAC	Kaufman	TWH Suggested
IM/ FP	100	60-80	62	62
Pediatrics	50	20	13	13
OB / GYN	11	11	13	11
General Surgery	06	10	07.7	07
Orthopedic Surgery	05	06	07	07
ENT	none given	04	03.2	04
Urology	02.5	03	03.1	03
Opthalmology	none given	05	03.3	04
Gastroenterology	02	02.5	01.7	04.5#
Neurology	01.5	03	02.2	02.2
Oncology	01	03.5	none	02.5
Cardiology	03	03	06	06
Dermatology	none given	03	02.3	03
Endocrinology	none given	01	01	01

considers the impact of endoscopy on the needs for GI physicians

TABLE 2

PRIMARY SERVICE AREA PHYSICIAN NEEDS ANALYSIS

Specialty	Need/ 100,000 Population	# MDs Needed	Current # MDs	Variance
FP / IM	62	44	37	7
Pediatrics	13	9	7.5	1.5
OB/ GYN	11	8	5	3
General Surgery	7	5	5	0
Orthopedics	7	5	4	1
ENT	4	2.8	2	1.2
Urology	3	2	2	-
Opthalmology	4	2.8	3	-
Gastroenterology	5	3.5	3	0
Neurology	2.2	1.5	1.2	-
Oncology	2.5	1.8	2	0
Cardiology	6	4.2	5	-
Dermatology	3	2.3	2	0.2
Endocrinology	1	0.7	1	-

Assumes a population of 70,626

TABLE 3

THE WESTERLY HOSPITAL
PCP PHYSICIAN NEEDS ANALYSIS

Community	*Population*	*# of MDs Needed 62/100,000*	*Total MDs*	*TWH MD*	*Variance*
Charlestown	8,081	5	5	1	0
Hopkinton	8,013	5	4	4	1
Westerly	23,500	14.6	12	11	2.6
Richmond	7,646	4.8	0	0	4.8
Stonington*	18,293	11.4	13	6	-
North Stonington	5,093	3.2	3	3	0
TOTAL	70,626	44	37	25	8.4

*Includes Stonington, Pawcatuck, and Mystic, CT

TABLE 4

PHYSICIANS MORE THAN 65 YEARS OLD AS OF JANUARY 1, 2012

Emergency Department	Dr. Conlin	60
Medicine	Dr. Dotolo (IM/ Card)	72
	Dr. Giancaspro (IM)	61
	Dr. Gillie (IM)	66
	Dr. Knisley (Oncology)	76
	Dr. Robin (Psychiatry)	74
	Dr. Serra (Nephrology)	63
	Dr. West (IM)	68
Obstetrics/Gynecology	Dr. Auth	62
	Dr. Greenlee	63
Surgery	Dr. Harrison	70
	Dr. Montemarano	72
	Dr. Ware	63
	Dr. Weaver	66

TABLE 5

RECRUITMENT SUMMARY

2012

General Surgery	? Replace	Prepare for Drs. Weaver, Ware, Montemarano

2013

PCP	? Replace	Prepare for Dr. Gillie
PCP	? Replace	Prepare for Dr. West
PCP	New	Town of Richmond
IM	? Replace	Prepare for Dr. Dotolo

Appendix 1
Family Medicine/Internal Medicine Providers within The Westerly Hospital Primary Care Area

Location	Physician	Specialty
Block Island RI	Janice Miller, M.D.	Internal Medicine
Charlestown RI	W. Scott Curtice, M.D.	Family Medicine
	Stuart V. Demirs, M.D.	Internal Medicine
	Mary Anne Longaere, M.D.	Family Medicine
	Thomas Warcup, D.O.	Family Medicine
Hope Valley RI /	John Bergeron, M.D.	Internal Medicine
	Christopher Campagnari, M.D.	Family Medicine
	Kristen Lichtenberg, M.D.	Family Medicine
	Lisa Menard-Manlove, M.D.	Family Medicine
Mystic CT	Thomas M. Blum, M.D.	Internal Medicine
(Stonington)	Rosemary Bontempi, M.D.	Internal Medicine
	Michael Feltes, M.D.	Family Medicine
	Warren Fields, M.D.	Internal Medicine
	Brandi Iovino, D.O. (Half Time)	Family Medicine
	Louis Iovino, D.O. (Half Time)	Family Medicine
	Roy M. Main, M.D.	Internal Medicine
	Judy Mamailay, M.D.	Internal Medicine
	James Scarles, M.D.	Internal Medicine
	David Schwindt, M.D.	Family Medicine
	Anne Timmerman, M.D.	Internal Medicine
	Edmund West, M.D.	Internal Medicine
North Stonington CT	Amanda Conti, M.D.	Internal Medicine/Peds.
	Stephana Pecher, M.D.	Internal Medicine
	Jersey Stocki, M.D. (Part Time)	Family Medicine
Pawcatuck CT	Brenda Applegate, M.D.	Family Medicine
(Stonington)		
Richmond RI	No Physicians Identified	
Stonington Borough	David Burchenal, M.D.	Internal Medicine
(Stonington CT)		

Location	Physician	Specialty
Westerly RI	Rocco Andreozzi, D.O.	Family Medicine
	John Beauchamp, M.D.	Internal Medicine
	Edsell Bernardo, M.D.	Internal Medicine
	Peter Bolton, M.D.	Internal Medicine
	Bartel Crisafi, M.D.	Family Medicine
	Robert Fox, M.D.	Internal Medicine
	Joseph Giancaspro, M.D.	Internal Medicine
	R. Bruce Gillie, M.D.	Internal Medicine
	Bernard Marzilli, M.D.	Family Medicine
	Lisa Noyes-Duguay, M.D.	Internal Medicine
	Job Sandoval, M.D.	Internal Medicine
	James Stuart, D.O.	Internal Medicine

Exhibit D1

Certification Note:

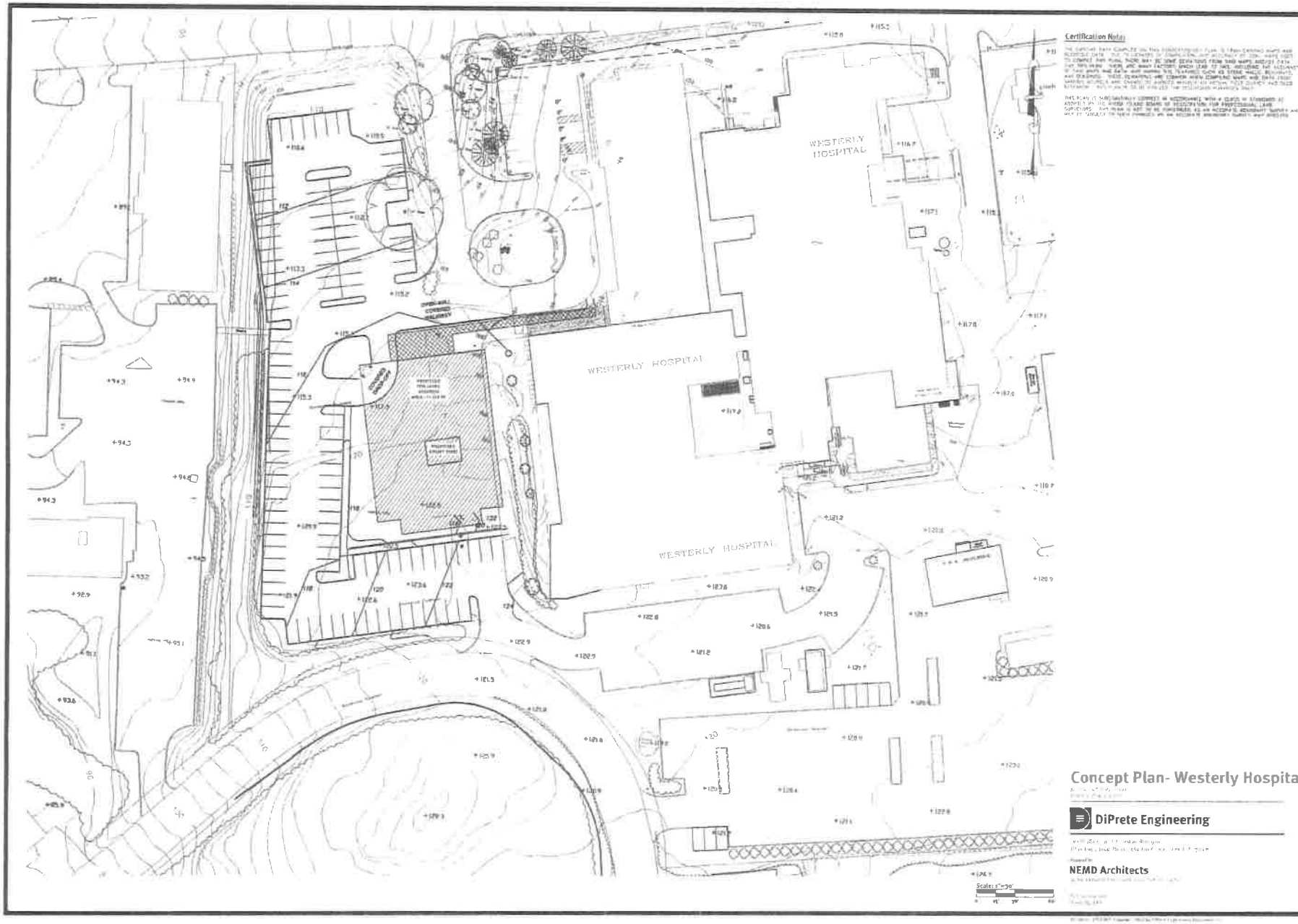
THE EXISTING DATA COMPILED ON THIS CONCEPT/STUDY PLAN IS FROM EXISTING MAPS AND REFERENCE DATA. DUE TO METHODS OF COMPILATION AND ACCURACY OF SOME MAPS USED TO COMPILE THIS PLAN, THERE MAY BE SOME DEVIATIONS FROM SHOT SHOTS AND/OR DATA AND THIS PLAN. THERE ARE MANY FACTORS WHICH LEAD TO THIS, DETERMINE THE ACCURACY OF SAID MAPS AND DATA, AND KNOWN SITE FEATURES SUCH AS STONE WALLS, BOUNDARIES, AND BUILDINGS. THESE DEVIATIONS ARE COMMON WHEN SYNOPTIC MAPS AND DATA FROM VARIOUS SOURCES ARE CHANGED OR ADDED WITHOUT AN ACTUAL FIELD SURVEY AND DOES RESEARCH. THIS PLAN IS TO BE UTILIZED FOR DISCUSSION PURPOSES ONLY.

THIS PLAN IS SUBSTANTIALLY CORRECT IN ACCORDANCE WITH A CLASS IV STANDARD AS ADOPTED BY THE RHODE ISLAND BOARD OF REGISTRATION FOR PROFESSIONAL LAND SURVEYORS. THIS PLAN IS NOT TO BE CONSTRUED AS AN ACCURATE BOUNDARY SURVEY AND MAY BE SUBJECT TO SUCH CHANGES AS AN ACCURATE BOUNDARY SURVEY MAY DISCLOSE.

Concept Plan- Westerly Hospital

DiPrete Engineering

NEMD Architects



Concept Plan- Westerly Hospital

DiPrete Engineering

NEMD Architects

PROPOSED FLOOR PLAN - JUNE 8, 2012

1/8" = 1'-0"

nemd architects

n|e|m|d architects, inc
architects | planners | interior designers

55 Bochenski Dunn Road, Suite 205 | Cranston, Rhode Island 02920
T: 401.463.3808 | F: 401.463.3819 | www.nemd.com |
nemd@nemd.com

WESTERLY HOSPITAL - BEHAVIORAL HEALTH

25 WELLS STREET, WESTERLY, RI

Exhibit D2

n|e|m|d architects, inc.
architects | planners | interior designers
95 Sockanosset Cross Road, Suite 203 | Cranston, Rhode Island 02920
T: 401.435.3532 | F: 401.435.3712 | www.nemd.com | nemd@nemd.com

June 25, 2012

Ms. Patricia K. Rocha, Attorney
Adler Pollock & Sheehan P.C.
One Citizens Plaza, 8th Floor
Providence, RI 02903

Re: Westerly Hospital
Behavioral Health Suite
25 Wells Street
Westerly, RI 02891-2934

Dear Ms. Rocha:

We have produced a preliminary design for this suite based on the owners program, the requirements for inpatient and outpatient suites outlined in both the 2006 AIA Guidelines for Design and Construction of Health Care Facilities and 2010 FGI Guidelines for Design and Construction of Health Care Facilities (Sections 2.5 Psychiatric Hospitals and 3.11 Psychiatric Outpatient Centers), RI State Building Code (IBC 2006 with amendments), NFPA 101 and 2010 ADA Standards for Accessible Design. Semi private rooms are included in this design. This is allowed in the 2010 version of the FGI Guidelines Section 2.5 - Specific Requirements for Psychiatric Hospital" and in Section 2.2 Specific Requirements for General Hospitals 2.2-2.14, "Psychiatric Nursing Unit" both of which refer to 2.5-2.2.2.1. 2.5-2.2.2.1 states the "maximum room capacity shall be two patients". The current layout includes seven two patient rooms and one private room. This ratio can be adjusted to meet programmatic requirements. The preliminary design as qualified herein is in full compliance with the current 2006 and 2010 Guidelines.

For this preliminary plan we have not shown all of the required equipment (e.g. under counter refrigerators, code cart, automatic medicine dispensers etc) or furniture. We have indicated some furniture to open the discussion as to a possible room layout. We have provided storage throughout the inpatient suite but have not indicated "use" (e.g. equipment storage, patient personal storage etc.). Where windows are required we have provided an outside wall but have not shown openings as the final locations has not been determined at this preliminary phase. We have not located all required staff spaces as some conversations with the user group(s) will be necessary to customize the facility to their needs. We have provided space to accommodate all required program functions. Finally we have

n|e|m|d
architects

not indicated rated construction but rated construction will be provided where required by the above noted codes and guidelines. This information along with all required M/E/P information will be included in final documents.
Please note that at this time only the 2006 Guidelines are in effect in Rhode Island. The state is planning to adopt the 2010 Guidelines at some time in the future.

Please contact me if you have any questions or concerns regarding this letter.

Sincerely,

Joanne O'Connell-Foster, RI License #2636
Principal,
n|e|m|d architects, RI COA A-14,010

Cc: Mr. Richard Munson, Westerly Hospital, 25 Wells Street, Westerly, MA 02891
Mr. Greg Mercurio, 1800 Mineral Spring Avenue, PO Box 309, North Providence, RI 02904
n|e|m|d file

Attachments: Preliminary Floor Plan dated June 21, 2012

Exhibit D6

(19), Twenty (20), Twenty-one (21), Twenty-two (22), Twenty-three (23), Twenty-four (24), Twenty-five (25), Twenty-six (26), Twenty-seven (27), Twenty-eight (28), Twenty-nine (29), Thirty (30), Thirty-one (31), Thirty-two (32), Thirty-three (33), Thirty-four (34), Thirty-five (35), Thirty-six (36), and Thirty-seven (37) on that plat entitled, "Cedar Lake Development Edward W. Smith Estates Inc., 1959, Westerly, R. I., Revised to Surveys by Rossi and Lewis May 1960, Scale 1 in. - 80 ft., Edward W. Smith Del.", which plat is on file in the Town Clerk's office in said Town of Westerly, to which reference is hereby had and made.

This conveyance is made SUBJECT to restrictions of record.

IN WITNESS WHEREOF, said JAMES ROMANELLA and SONS, INC., has caused these presents to be signed and its corporate seal to be hereunto affixed by its proper officers duly authorized this 16th day of December, 1960.

U.S.I.R.
$22.00
Stamps

JAMES ROMANELLA and SONS, INC. (Corporate Seal)
By Albert Romanella its President
and Joseph F. Romanella its Treasurer.

STATE OF RHODE ISLAND
COUNTY OF WASHINGTON

In Westerly, on the 16th day of December 1960, before me personally appeared the above named ALBERT ROMANELLA, President and JOSEPH F. ROMANELLA, Treasurer of JAMES ROMANELLA and SONS, INC., to me known and known by me to be the parties executing the foregoing instrument on behalf of said corporation and they acknowledged said instrument so executed, to be their free act and deed in their said capacities and the free act and deed of said corporation.

Harold B. Soloveitzik Notary Public

Received for Record December 21st A.D. 1960 at 3:16 o'clock P. M. and recorded.

Attest: [signature]
Town Clerk

B. 80 P. 548

DOWER REALTY COMPANY,

a Rhode Island corporation with an office and principal place of business in the Town of Westerly, County of Washington and State of Rhode Island, for consideration paid, grants to

THE WESTERLY HOSPITAL,

a Rhode Island corporation located in said Westerly, with WARRANTY COVENANTS, a certain tract or parcel of land, situated easterly of Beach Street, in the Town of Westerly, County of Washington and State of Rhode Island, bounded and described as follows:

Beginning at a point marked by a drill hole at a wall corner, saidpoint being the northwesterly corner of the tract herein described and the southwesterly corner of land of The Westerly Hospital, also the southeasterly corner of land now or formerly of Medical Building Associates of Westerly, Inc; thence running easterly, bounded northerly by land ofthe Westerly Hospital, a distance of Seven hundred twenty-five and 79/100 (725.79) feet to a drill hole at a wall intersection; thence turning an interior angle of 84° 13' and running southerly, bounded easterly by land of The Westerly Hospital, a distance of Two hundred sixty-three and 64/100 (263.64) feet to a drill hole; thence turning an interior angle of 88° 59' and running westerly bounded southerly by land now or formerly of Heirs of Catherine Haggerty a distance of Two hundred eighty-eight and 06/100 (288.06) feet to a drill hole at a wall corner; thence continuing westerly in the same straight line a distance of One hundred six and 20/100 (106.20) feet to the easterly line of a proposed street; thence turning an interior angle of 90° 00' and running northerly by and with the easterly line of the proposed street a distance of Twelve and

13/100 (12.13) feet to a point of curvature; thence following the arc of a circle from northerly to northwesterly with a radius of 149.07 feet and a central angle of 43° 54' a distance o One hundred fourteen and 22/100 (114.22) feet; thence running northwesterly by and with the line of the proposed street a distance of Forty-one and 75/100 (41.75) feet to a point of curvature; thence following the arc of a circle from the northwesterly to westerly with a radius of 125.69 feet and a central angle of 52° 49' a distance of One hundred fifteen and 86/100 (115.86) feet; thence running westerly a distance of Forty and 83/100 (40.83) feet to a point of curvature; thence following the arc of a circle from westerly to southwesterly with a radius of 210.73 feet and a central angle of 30° 08' a distance of One hundred ten and 82/10((110.82) feet; thence running southwesterly a distance of Twenty-one and 40/100 (21.40) feet; thence turning an interior angle of 49° 26' and running northerly a distance of Fifty and 13/1((50.13) feet to the point and place of beginning, this last course making an interior angle of 100° 31' with the first described course.

Being a portion of the Second Tract conveyed to said Dower Realty Company by Katherir W. Foster by a deed dated September 3, 1958 and recorded in the Westerly Land Evidence Records in Book 78, at page 40.

TOGETHER with the right, in common with the grantor, its successors and assigns, to to use said proposed street, and any extensions or relocations thereof, for purposes of ingres and egress from and to Beach Street and other public highways for the general corporate purpos of the grantee, by the grantee, its agents, servants and successors, until such time as said proposed street shall be accepted as a public highway by the appropriate municipal authorities the Town of Westerly.

IN WITNESS WHEREOF, DOWER REALTY COMPANY has caused this instrument to be signed and sealed by its duly authorized officers this 20 day of December, 1960.

U.S.I.R.
$8.25
Stamps

DOWER REALTY COMPANY (Corporate Seal)
By Walter B. Dower Its President, and by
Vernon B. Dower Its Treasurer

STATE OF RHODE ISLAND
County of Washington

In Westerly, on the 20 day of December, 1960, before me personally appeared WALTER B. DOWER, President of Dower Realty Company, and VERNON B. DOWER, Treasurer of Dower Realty Company, to me known and known by me to be the persons executing the foregoing instrument on behalf of Dower Realty Company, and they acknowledged said instrument, by them executed, to be their free act, individually and in their respective capacity, and the free act and deed of said Dower Realty Company.

(L.S.) Thomas D. Santoro Notary Public

Received for Record December 21st A.D. 1960 at 3:30 o'clock P. M. and recorded.

Attest: [signature]
Town Clerk

CHERENZIA & NIGRELLI, INC.,

a corporation established under the laws of the State of Rhode Island for consideration paid, grants to JOHN P. SELVIDIO and AMANDA SELVIDIO,

his wife, of the Town of Westerly in the State of Rhode Island, as Joint Tenants, WITH WARRANTY COVENANTS

That lot of land, with all buildings and improvements thereon, situated on the northerly side of Boiling Spring Avenue in the Town of Westerly and State of Rhode Island, laid out

deed,

John J. Dunn Notary Public

Received for Record April 10th, A. D. 1947 at 10:25 o'clock A. M. and recorded.

Attest: Charles K. Penner
Town Clerk.

B.65 P.99

I, ANNE PRICE EARLE

of Edgewood, County of Providence and State of Rhode Island, formerly of the Town of Westerly, County of Washington and State of Rhode Island for consideration paid, grant to

THE WESTERLY HOSPITAL

of Westerly, County of Washington and State of Rhode Island, a corporation duly incorporated under the Laws of the State of Rhode Island, with QUIT-CLAIM COVENANTS

A certain tract or parcel of land located on the southerly side of other property of The Westerly Hospital in the Town of Westerly, County of Washington and State of Rhode Island and more specifically described as follows, to wit:

Beginning at the northwesterly corner of the parcel herein conveyed at the intersection of two stone walls, said point also being the northeasterly corner of land of Anna E. Katherine and H. V. Foster Estate, said point also being on the southerly wall line of other land of this grantee; thence running southerly along a stone wall, bounded westerly by said Foster land three hundred (300) feet, more or less, to the southwesterly corner of the parcel herein conveyed at the intersection of this wall with another wall running in an easterly direction; thence running easterly along said other wall one hundred thirty (130) feet, more or less, to the westerly line of a proposed street as shown on Subdivision Plan of Land of Paul J. Raiko, said plan to be filed in the Land Evidence Records of said Town of Westerly, bounded southerly on this last dimension by land of Paul J. Raiko; thence running northerly along the westerly line of said proposed street and the extension north of the westerly line of said proposed street three hundred (300) feet, more or less, to the northeasterly corner of the premises hereby conveyed at other land of this grantee, bounded easterly by said proposed street which is now the property of Paul J. Raiko; thence running westerly one hundred thirty (130) feet, more or less, along the stone wall to the point and place of beginning, bounded northerly by other land of this grantee.

It is made a condition of this deed that these premises are to be used by the grantee for hospital purposes only and any buildings erected thereon shall not approach the proposed street on the east of said parcel nearer than thirty (30) feet.

Meaning and intending to convey a portion of the premises devised to this grantor by the will of Fannie F. S. Gavitt, said will having been duly proved and allowed by the Probate Court of said Town of Westerly.

I, Charles Crompton Earle husband of the grantor release to said grantee all my right of curtesy and all other interest in the aforedescribed premises.

Witness our hands this 27th day of March, 1947.

U.S.I.R.
$ .55
Stamps

Charles Crompton Earle

Anne Price Earle

State of Rhode Island, Etc.
COUNTY OF PROVIDENCE

In Providence, Rhode Island, on the 27th day of March, 1947 before me personally appeared Anne Price Earle and Charles Crompton Earle to me known and known by me to be the

parties executing the foregoing instrument, and they acknowledged said instrument, by them executed, to be their free act and deed.

(L.S.) Hope Graves Notary Public

Received for Record April 10th, A. D. 1947 at 12:00 o'clock Noon and recorded.

Attest: Charles H. Canman. Town Clerk.

I, OLIVER P. CRANDALL,

being unmarried, of the Town of Westerly, County of Washington and State of Rhode Island, for consideration paid, grant to HARRY FRANKLIN CRANDALL,

of the said Town of Westerly, County of Washington, and State of Rhode Island, with Quit-claim Covenants

All the right, title, interest, property, claim and demand which I now have, or of right ought to have, or claim, in and to the following described lots or parcels of land, with the buildings and improvements thereon standing, lying and being in the said Town of Westerly, County of Washington and State of Rhode Island, to wit:

Parcel No. 1. Bounded northerly by land of the heirs of Alonzo Cimiano and wife, deceased, easterly by the highway known as Canal Street, southerly by land formerly of Daniel S. Douglas, and westerly by the Canal Basin, so called. Being the same premises conveyed to Charles P. Chapman, deceased, by two deeds, the first of said deeds being from the heirs of Howse Babcock, deceased, and bearing date of July 26th, A. D. 1873, and being recorded in the Land Evidence of said Town of Westerly in Book No. 24, at page 108; and the second of said deeds being from Jesse L. Moss, and bearing date of May 1st, A. D. 1873, and being recorded in said book of Land Evidence at page 110; and both of said deeds and the records thereof are made a part of these presents.

Parcel No. 2. Bounded northerly by land formerly of Michael F. Martin and wife, easterly by lands of the heirs of Alonzo Cimiano, the above described first lot, lands formerly of Daniel S. Douglas and lands formerly of George A. Stanton, southerly by lands formerly of Nathan F. Dixon, and westerly by lands formerly of the heirs of said Nathan F. Dixon, deceased, or however otherwise the same may be bounded or described. Being the same premises conveyed to said Charles P. Chapman, deceased, by Horatio N. Campbell by deed dated June 26th, A. D. 1882, and recorded in the Land Evidence of said Town of Westerly in Book No. 25, at page 235; and said deed and the record thereof are made a part of these presents.

Parcel No. 3. is a part of what is or was called "the canal basin", and is bounded and described as follows, to wit:- Beginning at a stone post set in the ground twelve feet from a cement wall on said Chapman's land, thence running north 87 west one hundred and fifteen feet to a stone post set in the ground; thence running south 69 west to Pawcatuck River; thence northerly along said Pawcatuck River to land formerly of Michael F. Martin; thence running easterly to land of said Charles P. Chapman, deceased; thence along said Chapman land to the place of beginning; bounded southerly by land formerly of Joseph H. Potter, westerly by the Pawcatuck River, northerly by land formerly of Michael F. Martin, and easterly by land formerly of said Charles P. Chapman and land formerly of Harriet P. Dixon; being the same premises conveyed to said Charles P. Chapman, deceased, by Harriet P. Dixon by deed dated September 30th, A. D. 1887, and recorded in the Land Evidence of said Town of Westerly in Book No. 28, at page 203; and said deed and the record thereof are made a part of these presents.

Being the first three parcels of land described in a deed from Charles D. Chapman

Signed, sealed and delivered in presence of,

N J Ayling

Arthur M. Brown

U.S.I.M. $.50 stamp

Margaret B. Johnston, L.S.

as administratrix of the estate lying within the State of Rhode Island of Ellen Johnston, deceased.

State of Connecticut.
County of New London.

In the City of Norwich, in said County, on this 27th. day of August, A.D. 1925, before me personally appeared Margaret B. Johnston, to me known and known by me to be the administratrix of the estate lying within the State of Rhode Island, of Ellen Johnston late of said City of Norwich, deceased, and the party executing the aforegoing instrument, as such administratrix, and she acknowledged said instrument, by her executed as such administratrix, to be her free act and deed, as such administratrix.

(L.S.) Nelson J. Ayling Notary Public.

Received for Record September 1st, A.D. 1925, at 9.45 o'clock, A.M., and recorded.

Attest : Town Clerk.

B.50 P.79

KNOW ALL MEN BY THESE PRESENTS, that

THORP & TRAINER, INC.,

a corporation duly incorporated under the laws of the State of Rhode Island and having a place of business in the Town of Westerly, County of Washington, and State of Rhode Island, hereinafter called the Grantor, in consideration of a valuable sum of money in dollars to it paid by

THE WESTERLY HOSPITAL,

a corporation duly incorporated under the laws of the State of Rhode Island and having a place of business in the Town of Westerly aforesaid, receipt whereof is hereby acknowledged, do hereby remise, release, and forever quitclaim unto the said The Westerly Hospital, its successors and assigns forever, all the right, title, interest, property, claim, and demand which it now has or of right ought to have or claim in and to

two certain tracts or parcels of land situated on the southerly side of Wells Street, so-called, sometimes called Rocky Hill Road in said Town of Westerly, and bounded and described as follows to wit: First tract: that certain tract of land conveyed to Margaret McGowan by William D. Wells by deed dated October 1, 1892 and recorded in the Land Evidence Records of said Westerly in book number 24 at page 72. Reference to the same being hereby had and made and the same is made a part hereof. Second tract: that certain tract or parcel of land conveyed to Margaret McGowan by William D. Wells by deed dated January 6, 1885, and recorded in the Land Evidence Records of Westerly in book 26 at page 19. Reference to the same being hereby had and made and the same is made a part hereof. Meaning and intending to convey the same premises conveyed to this Grantor by two certain deeds, one from James M. Pendleton, Collector of Taxes of said Town of Westerly to this Grantor by deed dated April 10, 1925 and duly recorded in the Land Evidence Records of said Westerly. The other deed being from Margaret B. Johnston acting as administratrix of the estate of Ellen Johnston, deceased, to this Grantor by deed dated August 27, 1925 and duly recorded in the Land Evidence Records of said Westerly. Both of the above parcels of land are subject to the conditions concerning fencing as are of record.

TO HAVE AND TO HOLD, the same with all the rights, privileges, and appurtenances thereunto appertaining, unto and to the use of it the said The Westerly Hospital, its successors and assigns forever, and it the aforenamed Thorp & Trainer, Inc. for itself and for its successors and assigns covenants with the said The Westerly Hospital, its successors and assigns, that it will warrant and defend the aforedescribed premises unto the said The Westerly Hospital, its successors and assigns forever, against the lawful claims and de-

President and Secretary, hereunto duly authorized, and the Corporate Seal to be affixed hereunto, at Westerly, R.I. this 31st day of August in the year of our Lord Nineteen Hundred and twenty-five. Signed and sealed in the presence of:

Clarence E. Roche

THORP & TRAINER, INC. L.S.

Howard E. Thorp. Pres.
Rogers E. Trainer Sec'y.

STATE OF RHODE ISLAND
COUNTY OF WASHINGTON

In Westerly on the 31st day of August A.D. 1925,

before me personally appeared HOWARD E. THORP and ROGERS E. TRAINER, to me known and known by me to be respectively the President and Secretary of said Corporation, and they acknowledged said instrument by them executed to be the free act and deed of said Corporation and as well individually. (L.S.) Clarence E. Roche NOTARY PUBLIC.

Received for Record September 1st, A.D. 1926, at 9.45 o'clock, A.M., and recorded.

Attest : [signature]
Town Clerk.

KNOW ALL MEN BY THESE PRESENTS,

THAT WHEREAS Robert W. Perkins was appointed Ancillary Receiver of The Shore Line Electric Railway Company by the Superior Court within and for the County of Washington, State of Rhode Island and Providence Plantations on the 17th day of November, 1919, in the case of Frank Hill, et al. vs. The Shore Line Electric Railway Company, brought to said Court under a petition made to said Court dated October 1, 1919; and WHEREAS by decree entered on the 29th day of May, 1920, the receivership in said action of Frank Hill, et al., vs. The Shore Line Electric Railway Company was extended to the premises and property mortgaged to the Old Colony Trust Company in the action of Old Colony Trust Company vs. The Shore Line Electric Railway Company, et al., and said Robert W. Perkins was appointed Ancillary Receiver in said action; and WHEREAS said Robert W. Perkins has qualified in said proceedings and filed his bond as required by law; and WHEREAS John W. Sweeney, of Westerly, Rhode Island, conveyed to The Ashaway & Westerly Railway Company two tracts of land situated in said Town of Westerly by deed dated December 19, 1908, recorded in the Westerly Land Records, Volume 39, Page 293, which deed provided that said land was to be used for the purposes of an electric railway; and WHEREAS the two tracts of land covered by said deed of December 19, 1908, were afterwards conveyed to The Shore Line Electric Railway Company; and WHEREAS the railway over said land has been abandoned and removed and the Superior Court within and for the County of Washington, State of Rhode Island and Providence Plantations on July 6, 1925, passed an order authorizing and empowering the said Robert W. Perkins, Ancillary Receiver, as aforesaid, to execute and deliver to said John W. Sweeney a quit claim deed of all interest which said The Shore Line Electric Railway Company acquired in said land; NOW THEREFORE, KNOW YE that the said

Robert W. Pekins,

Ancillary Receiver, as aforesaid, pursuant to the order entered as aforesaid, has remised, released, and forever quit claimed, and does by these presents for himself and his successors justly and absolutely remise, release, and forever quitclaim unto the said John W. Sweeney, and to his heirs and assigns forever, all such right and title as The Shore Line Electric Railway Company, a corporation existing under the laws of the State of Connecticut, and located in the Town of Old Saybrook, County of Middlesex, in said State, has or ought to have in and to two tracts of land situated in the Town of Westerly, Rhode Island, bounded and described as follows: First tract. Beginning at the southwest corner of this tract adjoining the land now or formerly of The New York New Haven & Hartford Railroad Company; thence northerly by and with land now or formerly of Hannah Crandall thirty (30) feet;

signs forever against the lawful claims and demands of all persons.

In Witness Whereof, we have hereunto set our hands and seals this 31st day of March in the year of our Lord one thousand nine hundred and twenty four.

Executed in the presence of

Herbert W. Rathbun U.S.I.R. $1.00 stamp Elmer L. Briggs (seal)

Veronica D. Briggs (seal)

STATE OF RHODE ISLAND,
County of Washington

In Westerly on the 31st day of March, A.D. 1924,

before me personally appeared Elmer L. Briggs and Veronica D. Briggs, husband and wife, to me known and known by me to be the parties executing the foregoing instrument, and they acknowledged said instrument, by them executed, to be their free act and deed.

Herbert W. Rathbun Notary Public.

Received for Record April 5th, A.D. 1924, at 9.30 o'clock, A.M., and recorded.

Attest : Edward E. Whipple

Town Clerk.

B. 48 P. 559

Know all Men by these Presents, that I,

C. EDWARD GRINNELL,

of the Village of Mystic, County of New London, and State of Connecticut in consideration of the sum of Ten ($10.) Dollars and other valuable considerations to me paid by

The Westerly Hospital,

of Westerly, county of Washington and State of Rhode Island, a corporation duly incorporated under the laws of the State of Rhode Island the receipt whereof is hereby acknowledged, do hereby remise, release and forever QUITCLAIM unto the said The Westerly Hospital, its successors and assigns forever, all the right, title, interest, property, claim and demand which I now have, or of right ought to have, or claim, in and to

A certain tract or parcel of land lying and being in the Town of Westerly, county of Washington, and State of Rhode Island, bounded and described as follows, to-wit:- Beginning at the northeast corner of the premises hereby conveyed, adjoining land now or formerly of William D. Wells, at a point on the westerly side of East Avenue; thence running in a southerly direction by and with said East Avenue, a distance of sixty (60) feet; thence running westerly one hundred and eighty (180) feet; thence running northerly sixty (60) feet; thence running easterly one hundred and eighty (180) feet to the point and place of beginning; Bounded easterly by said East Avenue, southerly, westerly, and northerly by lands now or formerly of William D. Wells, or however otherwise the same may be bounded and described, meaning and intending to convey the same premises conveyed to this Grantor from Osmar D. Ballert by deed dated the 10th day of March 1924 and recorded in the Land Evidence Records of said Westerly. The Grantee, its successors and assigns are to build and forever maintain the fences on all sides of the premises hereby conveyed.

To Have and to Hold the same, with all rights, privileges and appurtenances thereunto appertaining, unto and to the use of it the said Grantee its successors and assigns forever. And I the aforenamed C. Edward Grinnell for myself and for my heirs, executors, and administrators, do covenant with the said Grantee its successors and assigns, that I will warrant and defend the aforedescribed premises unto the said Grantee, its successors and assigns, forever, against the lawful claims and demands of all persons claiming by, through, or under me. And I, covenant that I am unmarried

In testimony Whereof, I have hereunto set my hand and seal this 14th day of March in the year of our Lord one thousand nine hundred and twenty-four.

Everett Barns U.S.I.R. $ .50 stamp C. Edward Grinnell L.S.

Harold D. Livingstone

STATE OF RHODE ISLAND.
County of Washington

In Westerly on the 14th day of March A.D. 1924

before me personally appeared C. Edward Grinnell to me known, and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument, by him executed, to be his free act and deed.

Harold D. Livingstone NOTARY PUBLIC

Received for Record April 7th, A.D. 1924, at 2.30 o'clock, P.M., and recorded.

Attest : Everett E. Schlipple
Town Clerk.

Know all Men by these Presents, that I,

Dora J. Kenyon,

of the Town of Westerly, in the County of Washington and State of Rhode Island, hereinafter called the Grantor, in consideration of Ten Dollars and other valuable considerations, to me paid by William Robinson and Ruth Robinson,

of the Town of Stonington, in the County of New London and State of Connecticut, hereinafter called the Grantees, the receipt whereof is hereby acknowledged, do hereby give, grant, bargain, sell and convey unto the said Grantees, and their heirs and assigns forever

a certain lot or parcel of land lying and being at Pleasant View, in said Town of Westerly, and bounded and described as follows, to wit: Beginning at the southwesterly corner thereof on the easterly side of Benson avenue, so called, adjoining land of Quinn, thence run northerly seventy-five (75) feet; thence easterly one hundred fifty (150) feet; thence southerly seventy-five (75) feet; and thence westerly one hundred fifty (150) feet to point and place of beginning. Bounded westerly by said Benson avenue, northerly and easterly by other land of this Grantor, and southerly by said Quinn land. Said lot is shown and designated as Lot No. 19 on Benson avenue, on "Plan of Winnapaug Park Lots, owned by Alzada A. Saunders & B. F. Crandall, ~~~ 1911", now on file in the Town Clerk's Office in said Town of Westerly, and to which said plan reference is hereby had and made for a more complete description. This conveyance is made expressly subject to this restriction, to wit: That no building is to be erected or placed thereon within thirty (30) feet of said Benson avenue.

To Have and to Hold, the aforegranted premises, with all the rights, privileges and appurtenances thereunto belonging, unto and to the use of the said Grantees, and their heirs and assigns, forever." And I, the said Grantor, do hereby, for myself and for my heirs, executors, and administrators, covenant with the said Grantees and their heirs and assigns that I am lawfully seized in fee simple of the said granted premises; that the same are free from all incumbrances, except as aforesaid; that I have good right, full power and lawful authority to sell and convey the same in manner as aforesaid; that the said Grantees and their heirs and assigns shall by these presents at all times hereafter peaceably and quietly have and enjoy the said premises, and that, I the said Grantor will, and my heirs, executors and administrators, shall warrant and defend the same to the said Grantees and their heirs and assigns forever against the lawful claims and demands of all persons, except as aforesaid. And for the consideration aforesaid John L. Kenyon, husband of said Dora J. Kenyon, do hereby release all my right of curtesy in and to the said granted premises unto the said Grantees and their heirs and assigns, forever.

In Witness Whereof, we have hereunto set our hands and seals this 5th day of July, in the ~~~ of our Lord one thousand nine hundred and twenty-three.

appurtenances thereunto appertaining, unto and to the use of her, the said Delia L. Foley and her heirs and assigns forever. And I, the aforenamed James Foley, for myself and for my heirs, executors, and administrators, do covenant with the said Delia L. Foley and her heirs and assigns, that I will warrant and defend the aforedescribed premises unto the said Delia L. Foley, her heirs and assigns, forever, against the lawful claims and demands of all persons claiming by, through, or under me.

In Testimony Whereof, I have hereunto set my hand and seal this 17th day of September, in the year of our Lord one thousand nine hundred and twenty-three.

Signed and sealed in presence of

Everett E. Whipple

Mabel A. Saunders.

James his X mark Foley L.S.

STATE OF RHODE ISLAND,
County of Washington

In Westerly, on the 17th day of September A.D. 1923, before me personally appeared James Foley to me known, and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument, by him executed, to be his free act and deed.

Everett E. Whipple Town Clerk.

Received for Record September 17th, A.D. 1923, at 2.30 o'clock, P.M., and recorded.

Attest : Everett E. Whipple

Town Clerk.

B. 48 P. 254

Know all Men by these Presents, that I,

Charles Perry,

of the Town of Westerly, in the County of Washington, and State of Rhode Island, in consideration of the sum of Ten dollars to me paid by

The Westerly Hospital,

a corporation organized under the laws of the State of Rhode Island, and located in said Town of Westerly, the receipt whereof is hereby acknowledged, do hereby remise, release and forever QUITCLAIM unto it, the said The Westerly Hospital, its successors and assigns forever, all the right, title, interest, property, claim and demand which I now have, or of right ought to have, or claim, in and to

a certain tract or parcel of land, lying and being in said Town of Westerly, containing by estimation twelve and five tenths (12.5) acres, be the same more or less, and bounded and described as follows, to wit: Commencing at the southwest corner of the land herein conveyed adjoining land of H. Vernon Foster, at the corner of a stone wall, thence run north eighty seven (87) degrees, eighteen (18) minutes east, one thousand nine hundred and seven (1,907) feet, more or less, along said stone wall, to the southeast corner of the land herein conveyed, at the highway known as East Avenue, bounded southerly, partly by land of H. Vernon Foster, partly by land of Fannie S. Gavitt and partly by land of Elvira M. Perry; thence run north twenty six (26) degrees, forty seven (47) minutes east, two hundred eighty five (285) and three (3) tenths feet, more or less, to the northeast corner of the land herein conveyed, bounded easterly by said East Avenue; thence run north seventy eight (78) degrees, seventeen (17) minutes west, two hundred sixty one (261) and three (3) tenths feet, more or less; thence run north eighty two (82) degrees, twenty two (22) minutes west, five hundred sixty nine (569) and twenty five (25) hundredths feet, more or less, to a corner in a wall; thence run north eighty nine (89) degrees, thirty six (36) minutes west, one thousand seventy seven (1,077) and five (5) tenths feet, more or less to the easterly line of land of Bruce E. Gavitt, bounded northerly, partly by land of Nellie C. Donohue, partly by land of

Grantor; thence run south thirteen [illegible] degrees, fifty nine (59) minutes west, along [illegible] and terly line of land of said Horace E. Cavitt five (5) feet, bounded westerly by land of said Horace E. Cavitt; thence run North eighty seven (87) degrees, eight (8) minutes west, sixty seven (67) and nine (9) tenths feet, more or less, bounded northerly by land of said Horace E. Cavitt; thence run south eight (8) degrees, one (1) minute west, four hundred eighty nine (489) and six (6) tenths feet, more or less, to the place of beginning, bounded westerly partly by Wells Street, so called, partly by land of Roger F. Dunham and partly by land of H. Vernon Foster. Excepting the land described in a deed from William D. Wells to James Dowd, dated December 26, 1871, and recorded in the Land Evidence Records of said Town of Westerly, in Book No. 22, at page 709; and the land described in a deed from William D. Wells to Margaret McGowan, dated October 1, 1872, and recorded in the Land Evidence Records of said Town of Westerly, in Book No. 24, at page 72; and the land described in a deed from William D. Wells to Mary Long, dated June 23, 1884, and recorded in the Land Evidence Records of said Town of Westerly, in Book No. 23, at page 540; and the land described in a deed from William D. Wells to Margaret McGowan, dated January 6, 1885, and recorded in the Land Evidence Records of said Town of Westerly, in Book No. 25, at page 19; reference to said four deeds and the records thereof, being hereby had and made, and the same being made a part hereof.

To Have and to Hold the same, with all the rights, privileges and appurtenances thereunto appertaining, unto and to the use of it, the said The Westerly Hospital its successors and assigns forever. And I the aforenamed Charles Perry, for myself, and for my heirs, executors, and administrators, do covenant with the said The Westerly Hospital, its successors and assigns, that I will warrant and defend the aforedescribed premises unto the said The Westerly Hospital, its successors and assigns, forever, against the lawful claims and demands of all persons claiming by, through, or under me.

In Testimony Whereof, I have hereunto set my hand and seal this Third day of September in the year of our Lord one thousand nine hundred and twenty three

Signed and sealed in presence of

Harold D. Livingstone — U.S.I.R. $ .50 stamp — Charles Perry — L.S.

STATE OF RHODE ISLAND,
County of Washington

In Westerly on the fifteenth day of September A.D. 1923 before me personally appeared Charles Perry to me known and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument, by him executed, to be his free act and deed.

(L.S.) Harold D. Livingstone Notary Public

Received for Record September 17th, A.D. 1923, at 10.30 o'clock, A.M., and recorded.

Attest : [signature] Town Clerk.

KNOW ALL MEN BY THESE PRESENTS, that

THORP & TRAINER, INC.

a corporation duly incorporated under the laws of the State of Rhode Island, and having a place of business in Westerly, county of Washington and State of Rhode Island, hereinafter called the Grantor, in consideration of Ten ($10.) Dollars and other valuable considerations to it paid by

Samuel Hartridge and Mary A.E. Hartridge,

husband and wife, both of Westerly, county of Washington and State of Rhode Island, hereinafter called the Grantees, the receipt whereof is hereby acknowledged, does hereby give, grant, bargain, sell and convey unto the said Grantees, their heirs and assigns forever, a certain lot or parcel of land situate on the northerly side of At-

Exhibit D8

PAUL G. CORINA
UTILITIES SUPERINTENDENT

Town of Westerly
Rhode Island
UTILITIES DIVISION

68 White Rock Road
Westerly, RI 02891
TEL: (401) 348-2561
FAX: (401) 596-9512

June 7, 2012

Christopher Duhamel, PE, PLS, Vice President
DiPrete Engineering
Two Stafford Court
Cranston, RI 02920

Re: Proposed Building Addition: The Westerly Hospital

Dear Mr. Duhamel,

I am pleased to inform you that the Town of Westerly Water and Sewer Systems are available to service the proposed addition to the Westerly Hospital on 25 Wells Street. Prior to final approval, a Hydraulic Model Analysis will have to be run in accordance with the Town of Westerly Code of Ordinance "Chapter 1456" to evaluate water demands.

If you have any questions about this correspondence, please do not hesitate to contact me.

Very Truly Yours,

Paul G. Corina
Superintendent of Utilities

Exhibit F7

The Westerly Hospital
Geri-Psych CON Application
Response to Appendix F 7

Cash Flow 2013

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Cash Inflows														
Patient Cash	$	6,437,770	6,230,130	6,437,770	6,437,770	5,814,788	6,437,770	6,230,130	6,437,770	6,230,130	6,437,770	6,437,770	6,230,130	75,799,698
Other Cash		144,653	139,990	144,653	144,653	130,654	144,653	139,990	144,653	139,990	144,653	144,653	139,990	1,703,185
Geri-Psych		0	0	178,800	178,800	161,560	178,800	173,100	178,800	173,100	178,800	178,800	173,100	1,753,660
Total Inflows	$	6,582,423	6,370,120	6,761,223	6,761,223	6,107,002	6,761,223	6,543,220	6,761,223	6,543,220	6,761,223	6,761,223	6,543,220	79,256,543
Cash Outflows														
Personnel Costs	$	4,034,464	3,904,320	4,034,464	4,034,464	3,644,032	4,034,464	3,904,320	4,034,464	3,904,320	4,034,464	4,034,464	3,904,320	47,502,560
Supplies & Expenses		2,388,767	2,311,710	2,388,767	2,388,767	2,157,596	2,388,767	2,311,710	2,388,767	2,311,710	2,388,767	2,388,767	2,311,710	28,125,805
Geri-Psych Expense		103,917	103,917	103,917	103,917	103,917	103,917	103,917	103,917	103,917	103,917	103,917	103,917	1,247,004
Total Outflows	$	6,527,148	6,319,947	6,527,148	6,527,148	5,905,545	6,527,148	6,319,947	6,527,148	6,319,947	6,527,148	6,527,148	6,319,947	76,875,369
Net Cash Position														2,381,174

Includes Start-up Geriatric Expenses

Personnel Costs	$950,000	Start-up
S & E Costs	150,000	Start-up
Interest Costs	$147,000	
Total	$1,247,000	

Cash Flows FYE 2014

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Cash Inflows:													
Patient Cash	$ 6,503,676	6,293,910	6,503,676	6,503,676	6,166,260	6,503,676	6,293,910	6,503,676	6,293,910	6,503,676	6,503,676	6,293,910	76,867,632
Other Cash	144,653	139,990	144,653	144,653	130,654	144,653	139,990	144,653	139,990	144,653	144,653	139,990	1,703,185
Geri-Psych	390,910	378,300	390,910	390,910	353,080	390,910	378,300	390,910	378,300	390,910	390,910	378,300	4,602,720
Total Cash Inflows	$ 7,039,239	6,812,200	7,039,239	7,039,239	6,649,994	7,039,239	6,812,200	7,039,239	6,812,200	7,039,239	7,039,239	6,812,200	83,173,537
Cash Outflows													
Personnel Costs	$ 4,115,157	3,982,410	4,115,157	4,115,157	3,716,916	4,115,157	3,982,410	4,115,157	3,982,410	4,115,157	4,115,157	3,982,410	48,452,655
Supplies & Expenses	2,436,538	2,357,940	2,436,538	2,436,538	2,200,744	2,436,538	2,357,940	2,436,538	2,357,940	2,436,538	2,436,538	2,357,940	28,688,270
Geri-Psych Expenses	197,966	191,580	197,966	197,966	178,808	197,966	191,580	197,966	191,580	197,966	197,966	191,580	2,330,890
Total Outflows	$ 6,749,661	6,531,930	6,749,661	6,749,661	6,096,468	6,749,661	6,531,930	6,749,661	6,531,930	6,749,661	6,749,661	6,531,930	79,471,815
Net Cash Position	$												3,701,722

Geri Psych Expenses	Personnel Costs	1,934,000	Steady State
	S&E	250,000	Steady State
	Interest	147,000	Steady State
	Total	2,331,000	Steady State

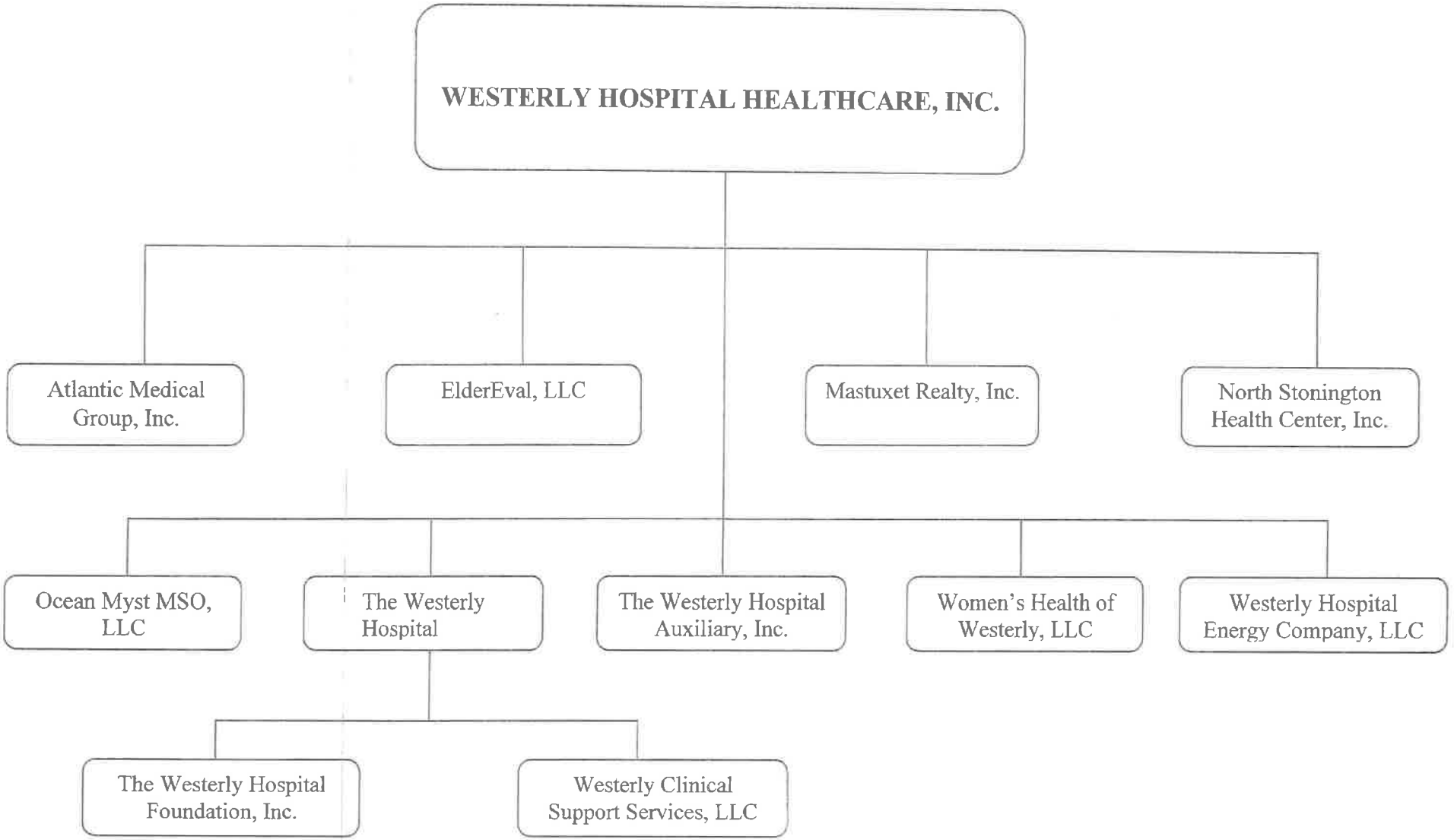
2014 Assumptions
Patient Rev increase 1%
Expenses increase 2%

FYE 2015

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Cash Inflows														
Patient Cash	$	6,568,962	6,357,090	6,568,962	6,568,962	6,225,228	6,568,962	6,357,090	6,568,962	6,357,090	6,568,962	6,568,962	6,357,090	77,636,322
Other Cash		144,653	139,990	144,653	144,653	130,654	144,653	139,990	144,653	139,990	144,653	144,653	139,990	1,703,185
Geri-Psych		394,816	382,080	394,816	394,816	356,608	394,816	382,080	394,816	382,080	394,816	394,816	382,080	4,648,640
Total Cash Inflows	$	7,108,431	6,879,160	7,108,431	7,108,431	6,712,490	7,108,431	6,879,160	7,108,431	6,879,160	7,108,431	7,108,431	6,879,160	83,988,147
Cash Outflows														
Personnel Costs	$	4,197,462	4,062,060	4,197,462	4,197,462	3,791,256	4,197,462	4,062,060	4,197,462	4,062,060	4,197,462	4,197,462	4,062,060	49,421,730
Supplies & Expenses		2,485,270	2,405,100	2,485,270	2,485,270	2,244,760	2,485,270	2,405,100	2,485,270	2,405,100	2,485,270	2,485,270	2,405,100	29,262,050
Geri-Psych Expenses		201,934	195,420	201,934	201,934	182,392	201,934	195,420	201,934	195,420	201,934	201,934	195,420	2,377,610
Total Cash Outflows	$	6,884,666	6,662,580	6,884,666	6,884,666	6,218,408	6,884,666	6,662,580	6,884,666	6,662,580	6,884,666	6,884,666	6,662,580	81,061,390
Net Cash Position	$													2,926,757

2015 Assumptions
Pat Rev Increase 1% (including Geri)
Op. Expense Increase 2% 2% including Geri)

Exhibit G5



Approved: October 2010

WESTERLY HOSPITAL HEALTHCARE (WHHC) SUBSIDIARIES

Atlantic Medical Group (AMG) - A subsidiary of WHHC established to recruit physicians and provide physician practice management. AMG now employs 31 physicians, 1 nurse practitioner, and 8 physician assistants.

Eldereval - A subsidiary of WHHC that provides full geriatric assessments and care management. It is not functioning.

Mastuxet Realty Inc - A subsidiary of WHHC established to acquire, hold, manage, maintain, develop, or dispose of real property for the benefit of Community Health of Westerly Inc, and its affiliates. It is not functioning.

North Stonington Health Center, Inc. (NSHC) - A subsidiary of WHHC established to offer a walk-in clinic, primary care services, physical therapy and lab services in North Stonington, CT.

Ocean Myst MSO, LLC - A subsidiary of WHHC, a management service organization that offers various support services to the medical staff.

The Westerly Hospital - A subsidiary of WHHC. Renders medical and surgical services to the community. Licensed for 125 beds.

The Westerly Hospital Auxiliary Inc. - A subsidiary of WHHC established to foster and increase the community's understanding of The Westerly Hospital while helping to provide supplementary financial assistance for hospital projects.

Westerly Hospital Energy Company, LLC - A subsidiary of WHHC established to purchase energy for WHHC and its subsidiaries.

Women's Health of Westerly LLC - An organized ambulatory care facility providing obstetrical and gynecological services by physicians employed by the LLC. A subsidiary of WHHC.

WESTERLY HOSPITAL SUBSIDIARIES

The Westerly Hospital Foundation - A subsidiary of The Westerly Hospital established to raise dollars for The Westerly Hospital.

Westerly Clinical Support Services LLC - A subsidiary of The Westerly Hospital established to conduct lab draw services at offsite locations. It is not functioning.