Department of Health

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November 25, 2024

VIA ELECTRONIC MAIL

Benjamin M. Mingle, President and Director
The Centurion Foundation, Inc.
One Buckhead Plz., 300 Peachtree Rd., NW, Suite 1030
Atlanta, GA 30305
ben@centurionmail.org

Re: The applications of The Centurion Foundation, Inc. CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, CharterCARE Our Lady of Fatima Hospital CharterCARE Blackstone Surgery Center, LLC, CharterCARE Home Health and Hospice, LLC, CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center for Changes in Effective Control of Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center; Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital; Prospect Blackstone Valley Surgicare, LLC d/b/a Blackstone Valley Surgicare; Prospect CharterCARE Home Health and Hospice, LLC d/b/a Prospect CharterCARE Home Health and Hospice; and Prospect CharterCARE RWMC, LLC d/b/a CharterCARE Sleep Disorders Center

Dear Benjamin Mingle:

Attached, as Appendix A, is the *Report of the Health Services Council on the Applications of The Centurion Foundation, Inc., sole member of CharterCARE Health of Rhode Island, Inc., sole member of CharterCARE Roger Williams Medical Center, CharterCARE Our Lady of Fatima Hospital, CharterCARE Blackstone Surgery Center, LLC, CharterCARE Home Health and Hospice, LLC, CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center for Changes in Effective Control of Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center; Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital;* ("Council's Report") that was reviewed and adopted by the Health Services Council ("Council") on November 19, 2024.

Any proposed change in owner, operator or lessee of a licensed health care facility is required by statute to be reviewed by the Council and approved by the state-licensing agency prior to implementation. The Change in Effective Control ("CEC") review is a public process that can take up to 90 days after initiation of review.

Pursuant to the requirements of R.I. Gen. Laws §§ 23-17-14.3 and 23-17-14.4, titled "Licensing of Health Care Facilities," The Centurion Foundation Inc., ("Centurion" or "Applicant")[1] filed CEC applications for the subject-licensed health care facilities. This request was made because the statute requires that any proposed change in owner, operator, or lessee of a licensed health care facility be reviewed by the Council and approved by the state-licensing agency prior to implementation.

In reviewing applications for a proposed change in the owner, operator, or lessee of any licensed health care facility, the Council considers the following criteria pursuant to R.I. Gen. Laws § 23-17-14.3:

(1) The character, commitment, competence, and standing in the community of the proposed owners, operators, or directors of the health care facility;

(2) In cases of initial licensure or of proposed change in owner, operator, or lessee, the extent to which the facility will provide or will continue to provide, without material effect on its viability at the time of initial licensure or of change of owner, operator, or lessee, safe and adequate treatment for individuals receiving the health care facility's services;

(3) The extent to which the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services; and

(4) The extent to which the facility will provide or will continue to provide appropriate access with respect to traditionally underserved populations and in consideration of the proposed continuation or termination of health care services by the health care facility.

This CEC Decision incorporates the complete record of the Council's review and findings pursuant to § R.I. Gen. Laws 23-17-14.3 and § 23-17-14.4, as can be found in the attached Council's Report. I find that the deliberation and analysis of facts adopted in the Council's Report satisfies the requirements of the CEC criteria.

Centurion, as the Applicant, submitted its CEC applications of the five (5) subject-licensed health care facilities in accordance with the statutory requirements. The structure of the transaction is a sale of substantially all of the assets of Prospect CharterCARE, LLC ("PCC"), to Centurion, a nonprofit entity, pursuant to the parties' Asset Purchase Agreement dated November 18, 2022, as amended on April 18, 2023, and further amended on November 7, 2023.

[1] Centurion is an Atlanta-based nonprofit corporation formed in 1996 and consists of principals including Benjamin M. Mingle, Chairman and Chief Executive Officer, Gregory Grove, Founder, Vice-Chairman, and Secretary, and Steve Lovoy, Chief Financial Officer. Centurion states it provides services, programs and activities that center on charitable foundation leases to further the mission of other nonprofits. Centurion further states it will become the ultimate corporate parent to the newly formed nonprofit entities that will hold the assets.

Prospect Medical Holdings, Inc. ("PMH"), as the current owner, has struggled financially and operationally to maintain the licensed health care facilities and expressed its desire to exit the Rhode Island market. The process of identifying and proffering buyers of hospitals and health care facilities takes place prior to the Hospital Conversions Act ("HCA") and CEC regulatory review process by the Rhode Island Department of Health ("RIDOH"). The seller, PMH, undertook a thorough search to find a buyer for the PCC entities, resulting in Centurion as its sole viable candidate. RIDOH is charged with reviewing the applications as submitted. While concerns were noted regarding the suitability of the Applicant, the applications present some positive attributes. The Applicant offers the opportunity to revert ownership and operations to a locally owned and operated nonprofit model. Despite lacking direct hospital management experience, the applications propose to retain the experienced local management.

On May 26, 2023, RIDOH received the first submission of the CEC applications for PCC's licensed health care facilities. This submission contained four (4) CEC applications pertaining to the following entities: CharterCARE Roger Williams Medical Center ("CharterCARE RWMC"), CharterCARE Our Lady of Fatima Hospital ("CharterCARE OLF"), CharterCARE Blackstone Surgery Center, LLC ("CharterCARE BVS"), and CharterCARE Home Health and Hospice, LLC ("CharterCARE Home Health"). On June 30, 2023, RIDOH then received new copies of the CEC applications, as changes were made by the parties to Appendix A in the CharterCARE RWMC and CharterCARE OLF CEC applications and to the signature pages in all CEC applications.

On December 11, 2023, RIDOH received four (4) CEC applications, one for each of the licensed facilities that were resubmitted by the parties, as a result of changes to its proposal, excluding references to a consultant previously contemplated. RIDOH initiated a meeting with the Applicant and its representatives to discuss RIDOH's concerns around issues, such as financing and ownership structure, that were identified in the CEC applications. The meeting took place on February 12, 2024; and on February 28, 2024, a letter was issued to Centurion in follow-up to the meeting that outlined these areas of concern.

On March 8, 2024, RIDOH issued a deficiency letter to Centurion that identified information necessary to determine completeness. On April 18, 2024, RIDOH received five (5) CEC applications responsive to the March 8, 2024, deficiency letter. This submission included a CEC application for the separately licensed CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center ("CharterCARE Sleep Disorders Center") as required, in addition to the four (4) CEC applications for the aforementioned licensed health care facilities.

On May 31, 2024, RIDOH issued a second deficiency letter to Centurion that further identified information necessary to determine completeness. Several months later, on August 23, 2024, RIDOH received five (5) CEC applications for RIDOH's review. On September 26, 2024, RIDOH issued a third deficiency letter to Centurion identifying the outstanding information required to deem the applications complete. Additionally, the deficiency letter issued by RIDOH highlighted

two outstanding concerns regarding: (1) the lack of detail and documentation of the legal transfer of assets from Centurion to CharterCARE Health of Rhode Island, Inc. ("CharterCARE Health of Rhode Island") and to each of the licensees; and (2) amending the Corporate Services Agreement ("CSA") to reflect Centurion's accountability and responsibility for patient care/delivery of health care services.

On October 3, 2024, RIDOH received five (5) CEC applications that included the addition of the unexecuted Bill of Sale and Assumption Agreements for each of the licensees and an amended CSA. The Applicant stated that it would supplement the additional deficiencies throughout the CEC review process.

On October 7, 2024, RIDOH deemed the CEC applications acceptable in form, based upon, among other things, RIDOH's understanding that Article 1 Sections 1.3(A) and (B) "Limited Nature of Sole Member's Responsibility" of the CSA contained within the CEC applications, solely pertains to Centurion's role and responsibilities in providing administrative services to CharterCARE Health of Rhode Island as distinguished from Centurion's role and responsibilities as the sole member of CharterCARE Health of Rhode Island and its subsidiary licensed health care facilities. Accordingly, the review of the applications commenced on October 8, 2024.

RIDOH received an additional submission of the five (5) CEC applications and a corresponding chart identifying the supplemental information and documents submitted on November 8, 2024.

RIDOH accepts the recommendation of the Council and hereby approves the applications, and adopts the attached Council's Report, subject to conditions one (1) through seven (7) of the eight (8) conditions set forth in the Council's Report:

1. that the applications be implemented as approved;

2. that data, including but not limited to, finances, utilization, and demographic resident information, be furnished to the state agency, upon request;

3. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center maintain accreditation from a nationally recognized accrediting agency;

4. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center shall conduct national criminal background checks on their employees prior to employment;

5. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center establish and put into effect formal agreements for referral of charity care cases with a minimum of one 501(c)(3) licensed community health center in their service areas within sixty (60) days of approval;

6. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center cooperate with 501(c)(3) providers who refer clients for charity care services to the Applicant's facilities to pre-certify such referred individuals to qualify for charity care services at the Applicant's facilities; and

7. for the CharterCARE RWMC and CharterCARE OLF applications, that the Applicant comply with all applicable conditions as set forth in RIDOH's HCA Decision, dated June 20, 2024, and RIDOH's subsequent related response letters.

Subsequent to the Council's adoption of the Council's Report, RIDOH received the attached correspondence (Appendix B), dated November 21, 2024, from Charles P. Sukurs, Esq., Centurion's transaction counsel, stated among other things, "*proposed Condition 8 presents an uncertainty regarding the composition of the Board in the future and such uncertainty must be disclosed to investors of the bonds. As you know, this transaction will be financed through the issuance of bonds by RIHEBC. The inconsistency and uncertainty resulting from proposed Condition 8 is a material change that could adversely impact the bond financing and consummation of the transaction*." Attorney Sukurs further stated, "[*a*]*s transaction counsel to Centurion, I cannot recommend that the Centurion Board approve the Transaction when this proposed HSC condition puts in doubt Centurion's ability to ensure compliance with the HCA Conditions*."

While taking into consideration the Council's thoughtful and deliberative recommendation for proposing condition eight (8), RIDOH must balance the Council's recommendation with the previously imposed conditions, pursuant to the HCA. Centurion, as a transacting party, is already required to comply with the HCA Decision[2] and RIDOH's subsequent response letter, dated September 26, 2024, related to HCA Condition of Approval number twelve (12). Being the majority presence on the boards of directors places Centurion in the best position to comply with conditions. RIDOH also considered the most recent information provided by the Applicant and its potential impact on Centurion successfully obtaining financing. The HCA subjects Centurion to ongoing monitoring, which includes financial monitoring in accordance with the Conditions of Approval of the HCA Decision for a minimum of five (5) years.

As such, RIDOH varies from the recommendations of the Council, and modifies Condition of Approval number eight (8), as follows:

8. that three (3) years after the date of the closing of the Proposed Transaction and on an annual basis thereafter for an additional two (2) years, the Applicant will submit a written report to RIDOH, including any proposed reconfiguration of the composition of the boards of directors, that will not propose a decrease below 40% of independent (i.e., not employed by or affiliated with, Centurion or its affiliates) board representation, but may

[2] RIDOH issued its decision on the HCA Initial Application of Centurion, CharterCARE Health of Rhode Island, CharterCARE RWMC, CharterCARE OLF, Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC (the "HCA Decision") on June 20, 2024.

increase the percentage of independent (i.e., not employed by or affiliated with, Centurion or its affiliates) board representation.

Furthermore, the HCA Decision, its Conditions of Approval, RIDOH's subsequent related response letters to the HCA Decision, are incorporated and adopted by reference as fully set forth in this CEC Decision.

Approval and implementation of these applications will result in the termination of:

(1) the existing hospital license issued to Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center and the issuance of a new hospital license to CharterCARE Roger Williams Medical Center;

(2) the existing hospital license issued to Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital and the issuance of a new hospital license to CharterCARE Our Lady of Fatima Hospital;

(3) the existing freestanding ambulatory surgery center license issued to Prospect Blackstone Valley Surgicare, LLC and the issuance of a new freestanding ambulatory surgery center license to CharterCARE Blackstone Surgery Center, LLC;

(4) the existing home nursing care provider license issued to Prospect CharterCARE Home Health and Hospice, LLC d/b/a Prospect CharterCARE Home Health and Hospice and the issuance of a new home nursing care provider license to CharterCARE Home Health and Hospice, LLC; and

(5) the existing licensed organized ambulatory care facility license issued to Prospect CharterCARE RWMC, LLC d/b/a CharterCARE Sleep Disorders Center and the issuance of a new organized ambulatory care facility license issued to CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center.

Additionally, please complete the attached license applications, in Appendix C, at least two weeks in advance of the closing in order to implement the changes in effective control in a timely manner. Please contact the Center for Health Facilities Regulations at (401) 222-2566 with regards to any questions regarding the license applications.

Sincerely,

Jerome Larkin, MD
Director, Rhode Island Department of Health

Attachments

Appendix A

REPORT OF THE HEALTH SERVICES COUNCIL
ON THE APPLICATIONS OF THE CENTURION FOUNDATION, INC.,
SOLE MEMBER OF CHARTERCARE HEALTH OF RHODE ISLAND, INC., SOLE
MEMBER OF CHARTERCARE ROGER WILLIAMS MEDICAL CENTER,
CHARTERCARE OUR LADY OF FATIMA HOSPITAL, CHARTERCARE
BLACKSTONE SURGERY CENTER, LLC, CHARTERCARE HOME HEALTH AND
HOSPICE, LLC, CHARTERCARE ROGER WILLIAMS MEDICAL CENTER D/B/A
CHARTERCARE SLEEP DISORDERS CENTER
FOR CHANGES IN EFFECTIVE CONTROL OF:

- PROSPECT CHARTERCARE RWMC, LLC D/B/A ROGER WILLIAMS MEDICAL CENTER;
- PROSPECT CHARTERCARE SJHSRI, LLC D/B/A OUR LADY OF FATIMA HOSPITAL;
- PROSPECT BLACKSTONE VALLEY SURGICARE, LLC D/B/A BLACKSTONE VALLEY SURGICARE;
- PROSPECT CHARTERCARE HOME HEALTH AND HOSPICE, LLC D/B/A PROSPECT CHARTERCARE HOME HEALTH AND HOSPICE; AND
- PROSPECT CHARTERCARE RWMC, LLC D/B/A CHARTERCARE SLEEP DISORDERS CENTER

Health Services Council

Victoria Almeida, Esq. (Chair)
Jennifer Azevedo, Esq.
Raymond Coia, Esq. (Secretary)
Daniel Connors, Esq.
Lindsay Lang, Esq.
Robert Mancini (Vice-Chair)
Emily Maranjian, Esq.
Theresa Petisce
John Sepe
Michael Walker

Submitted to the
Health Services Council to
Review and Adopt
November 19, 2024

Adopted by the
Health Services Council
November 19, 2024

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I. SYNOPSIS

The Health Services Council ("Council") recommends that the applications of The Centurion Foundation, Inc. ("Centurion" or "Applicant"), sole member of CharterCARE Health of Rhode Island, Inc. ("CharterCARE Health of Rhode Island"), sole member of CharterCARE Roger Williams Medical Center, Inc. ("CharterCARE RWMC"), CharterCARE Our Lady of Fatima Hospital, Inc. ("CharterCARE OLF"), CharterCARE Blackstone Surgery Center, LLC ("CharterCARE BVS"), CharterCARE Home Health and Hospice, LLC (CharterCARE Home Health"), CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center ("CharterCARE Sleep Disorders Center")[1] for Changes in Effective Control ("CEC") of Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center ("RWMC"), a licensed acute care hospital in Providence, Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital ("OLF"), a licensed acute care hospital in North Providence,[2] Prospect Blackstone Valley Surgicare, LLC ("Prospect BVS"), a licensed freestanding ambulatory surgical center in Johnston, Prospect CharterCARE Home Health and Hospice, LLC ("Prospect HH&H"), a licensed home nursing care provider in Providence, and Prospect CharterCARE RWMC**,** LLC d/b/a CharterCARE Sleep Disorders Center ("Sleep Center"), a licensed Organized Ambulatory Care Facility, located in Johnston, Rhode Island, be approved.

II. PROPOSAL DESCRIPTION

The structure of the transaction as outlined in the applications is a sale of substantially all of the assets of Prospect CharterCARE, LLC ("PCC")[3], a for-profit entity, to Centurion, a non-profit entity, pursuant to the parties' Asset Purchase Agreement ("APA") dated November 18, 2022, as amended on April 18, 2023, and further amended on November 7, 2023 (the "Proposed Transaction"). Centurion is an Atlanta-based non-profit corporation formed in 1996 and consists of principals including Benjamin M. Mingle, Chairman and Chief Executive Officer ("CEO"), Gregory Grove, Founder, Vice-Chairman, and Secretary, and Steve Lovoy, Chief Financial Officer. The Applicant states that it provides services, programs and activities that center on charitable foundation leases to further the mission of other non-profits, will become the ultimate corporate parent to the newly formed non-profit entities that Centurion states will hold the assets. The newly formed entities include CharterCARE Health of Rhode Island, CharterCARE RWMC, CharterCARE OLF, CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center. According to the Applicant, CharterCARE RWMC and CharterCARE OLF, respectively, will own and operate the Existing Hospitals. CharterCARE BVS will lease the

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

[2] RWMC and OLF are collectively referred to as the "Existing Hospitals." CharterCARE RWMC and CharterCARE OLF are collectively referred to as the "New Hospitals."

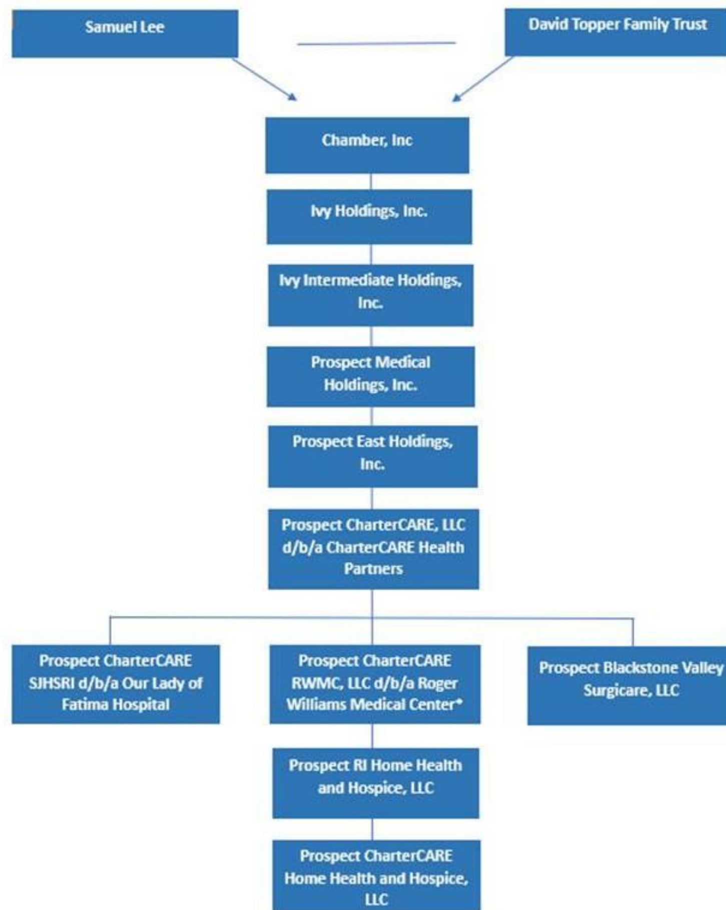
[3] PCC is the sole member of Prospect CharterCARE SJHSRI d/b/a Our Lady of Fatima Hospital, Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center, and Prospect Blackstone Valley Surgicare, LLC. PCC's ultimate parent is Chamber, Inc.

real estate for the licensed freestanding ambulatory surgical center operated by CharterCARE BVS. CharterCARE RWMC will own the real estate for the office for the licensed home health agency operated by CharterCARE Home Health. CharterCARE RWMC will own the real estate for CharterCARE Sleep Disorders Center as CharterCARE Sleep Disorders Center operates within the licensed hospital. While the New CharterCARE System entities are not parties to the APA, Centurion has asserted the operations, real estate, personal property, contracts and liabilities will be obtained directly by the respective New CharterCARE entities through the provisions of the APA. The applications state that to the extent any amendment to the APA is necessary at the time of closing to reflect the direct purchase by the New CharterCARE System entities, the parties will do so without any other change to the terms of the APA. The Applicant provided draft Bill of Sale and Assignment and Assumption Agreements related to the transfer of personal property, contracts and liabilities. The Applicant asserts leased real estate will be transferred via an Assignment and Assumption Agreement of Real Property Lease and the owned real estate will be transferred via different deeds, to be obtained at closing. This assignment of rights of the APA is a condition of approval of RIDOH's HCA Decision.[4]

The pre- and post-transaction organizational charts are below, Exhibit 1 and Exhibit 2, respectively.

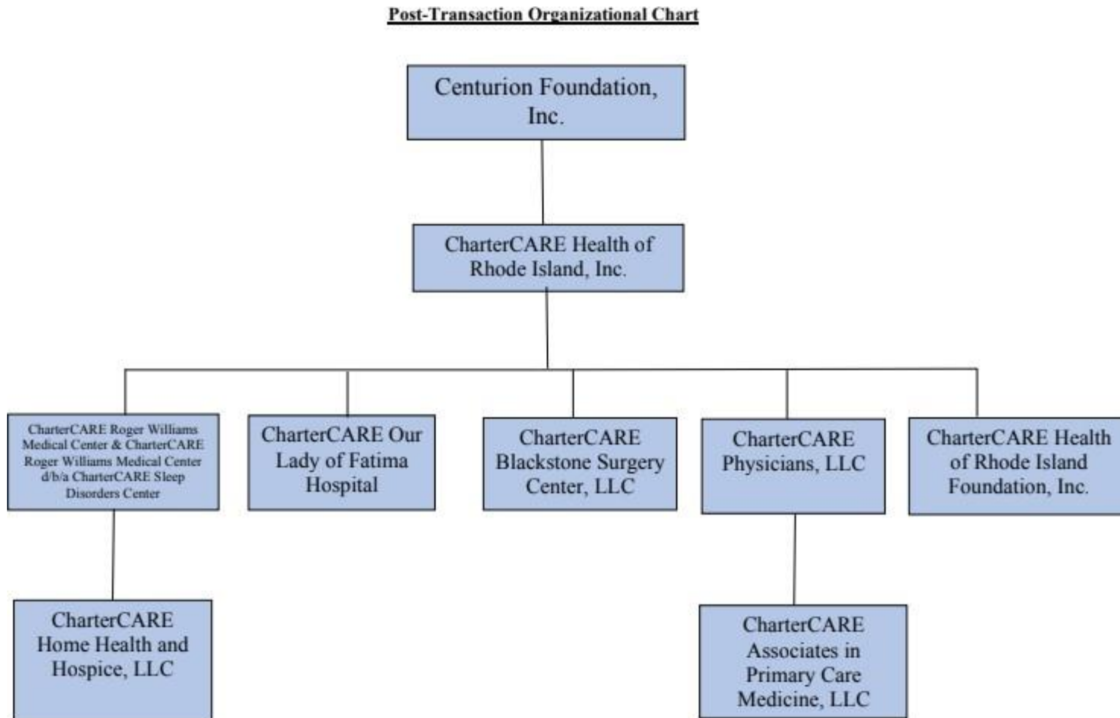
[4] RIDOH issued a decision of approval of the Hospital Conversions Act Initial Application related to the Proposed Transaction on June 20, 2024 titled "Decision of Approval with Conditions on the Hospital Conversions Act Initial Application of The Centurion Foundation, Inc., CharterCARE Health of Rhode Island, Inc., CharterCARE Roger Williams Medical Center, Inc., CharterCARE Our Lady of Fatima Hospital, Inc., Chamber, Inc., Ivy Holdings, Inc., Ivy Intermediate Holdings, Inc., Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect CharterCARE, LLC, Prospect CharterCARE SJHSRI, LLC, and Prospect CharterCARE RWMC, LLC (the "HCA Decision").

Exhibit 1: Pre-Transaction Structure



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

Exhibit 2: Post-Transaction Proposed Structure



Following the close of the Proposed Transaction, the New CharterCARE System will be a non-profit status, which the Applicant asserts will result in a "more sustainable level of performance." The New CharterCARE System will be governed by a local board of directors and a local management team. While Centurion is the ultimate corporate parent, the Applicant represents that Centurion will not have a day-to-day role in operating the New Hospitals. Centurion, among other things, refers to itself as a "sponsor" of the New CharterCARE System, where it will "provide guidance and expertise," as necessary. After closing, the New CharterCARE System will be governed by a board of directors including local community members and Centurion representatives. The New CharterCARE System will be led by the existing PCC CEO, Jeffrey Liebman, and other members of the current management team.

As represented by the Applicant, pursuant to the APA, the purchase price was agreed to be the fair market value of the assets, which was determined to be in the range of $139.0 million to $161.0 million. Subsequent to the valuation, the parties agreed to a purchase price of $160.0 million. The APA was later amended to reduce the purchase price to $80 million, which has been described by the Applicant as the net purchase price. The Applicant anticipates that the New CharterCARE System will finance the $160 million value, plus closing costs, and place $80 million of cash on the New CharterCARE System's balance sheet at closing, which is intended to equal approximately eighty (80) days cash on hand. Additionally, the Applicant anticipates that the New CharterCARE System will either assume existing PACE loans or satisfy that debt with newly issued debt.

The Applicant asserts that excluding the PACE loans, the total net debt associated with the proposal is approximately $192 million, comprised of $91 million taxable and $41 million tax-exempt bonds. Additionally, in its June 20, 2024, HCA Decision, the Rhode Island Attorney General required that the Transacting Parties contribute $66.8 million into a Hospital Fund – a restricted non-permanent fund for the sole benefit of the New Hospitals. Accordingly, including transaction costs and fees, the Applicant states that the total capital cost of the proposal is $258,893,000. As proposed, the New CharterCARE System (as opposed to Centurion) will be responsible for the financial obligations associated with the Proposed Transaction, such as issuing the bonds. As proposed, Centurion has stated that they will not provide monetary support to the New CharterCARE System for capital projects or operating losses.

The Proposed Transaction contemplates implementation of improvement initiatives ("Improvement Initiatives") and execution of a transition plan. The Applicant's presentation to the Council stated that there are five (5) categories that will return New CharterCARE System to sustainability. The five (5) categories include not for profit status, volume/service growth, workforce, expense reduction, and revenue cycle/reimbursement.

The Proposed Transaction involves five (5) licensed healthcare facilities that provide services as follows:

RWMC, is a licensed acute care hospital (license no. HOS00133), for 220 beds, in Providence. RWMC is an academic medical center affiliated with Boston University School of Medicine. According to the Applicant, services currently offered include:

- Medical/Surgical Services and Intensive/Coronary Care Unit
- Inpatient and Outpatient Rehabilitation Services
- Ambulatory Care Services
- Emergency Services
- Inpatient and Outpatient Psychiatric/Mental Health/Addiction Medicine
- Laboratory/Pathology
- Inpatient and Outpatients Cancer Services
- Wound Care/Hyperbaric Services
- Dermatology

OLF is a licensed acute care hospital (license no. HOS00132), for 278 beds, in North Providence. According to the Applicant, services currently offered include:

- Medical/Surgical Services and Intensive/Coronary Care Unit
- Inpatient and Outpatient Rehabilitation Services
- Ambulatory Care Services
- Emergency Services
- Inpatient and Outpatient Psychiatric/Mental Health/Addiction Medicine Services
- Diagnostic Imaging and Interventional/Radiology Services
- Wound Care/Hyperbaric Services
- Dermatology
- Health center services

Prospect BVS, a licensed freestanding, multi-specialty ambulatory surgery center (license no. FAS01032), located in Johnston, Rhode Island. According to the Applicant, services currently offered include:

- Gastroenterology
- General Surgery
- Lithotripsy
- Ophthalmology
- Oral Surgery
- Orthopedic
- Plastic Surgery
- Podiatry
- Urology
- Pain Management

Prospect HH&H, a licensed home nursing care provider (license no. HNCP02373), located in Providence, Rhode Island. According to the Applicant, services currently offered include:

- Comprehensive home environment assessments
- Medical evaluations/assessments
- Pain and disease management
- Pain and family education
- Wound care (vacuum-assisted closure – VAC)
- Surgical dressing changes
- Communication with physician
- Telehealth program
- Pharmacy consult
- Physical therapy
- Occupational therapy
- Speech therapy
- Nutritional support (including total parenteral and enteral)
- Medical social services (including psychosocial for patients and families)
- Certified nursing assistants
- Lifeline
- Palliative care

Sleep Center, a licensed Organized Ambulatory Care Facility (license no. ACF01620), located in Johnston, Rhode Island. According to the Applicant, the Sleep Center offers treatment options to help patients with insomnia, sleep apnea, and other common disorders.

According to the Applicant, there are no current plans to add, terminate, expand or reduce services at the licensed facilities as a result of the Proposed Transaction. The Applicant states that they plan to expand and improve existing services to increase the use of those existing services.

III. INTRODUCTION

Pursuant to the requirements of R.I. Gen. Laws §§ 23-17-14.3 and 23-17-14.4, titled "Licensing of Health Care Facilities," the Applicant filed applications for a change in effective control of the subject-licensed facilities. This request is being made because the statute requires that any proposed change in owner, operator, or lessee of a licensed health care facility be reviewed by the Council and approved by the state-licensing agency prior to implementation.

Staff reviewed the applications, found them to be acceptable in form, and notified the Applicant and the general public by a notice on the Rhode Island Department of Health's ("RIDOH") website and e-mail that the review would commence on October 8, 2024. The applications and a corresponding chart reflecting supplemental information and documents submitted on November 8, 2024 are included in the following links:

CharterCARE Roger Williams Medical Center's CEC Application

CharterCARE Our Lady of Fatima Hospital's CEC Application

CharterCARE Blackstone Surgery Center, LLC's CEC Application

CharterCARE Home Health and Hospice, LLC's CEC Application

CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center's CEC Application

The notice also advised that all persons wishing to comment on the applications submit their comments to the state agency by November 6, 2024, when practicable.

During the course of the review, over one hundred (100) written comments were received or submitted for consideration. The written comments included comments in support of the proposal, comments in opposition of the proposal, and comments that raised concerns about the proposal.

All written public comments that were received during the course of the CEC review may be accessed via the following link and all written public comments that were received in connection with the HCA review may be accessed via the link on Page 14 of the HCA Decision:

Written public comment(s)

The following documents related to the HCA Decision that were provided by RIDOH staff may be accessed via the following links:

June 20, 2024 HCA Decision

Letters from RIDOH in follow up to June 20, 2024 HCA Decision Condition of Approval

The Council reviewed the Applicant's proposal and held a series of three (3) Council meetings open to the public. The applications were heard before the Council on the following dates:

- October 22, 2024;
- October 29, 2024; and
- November 12, 2024.

The Applicant and its legal counsel were in attendance at all such meetings.

The Applicant's representatives presented its applications at the October 22, 2024, meeting, and the presentation may be access via the following link:

Presentation of Centurion's CEC Applications

Additionally, the following individuals addressed the Council on behalf on the Applicant during the October 22, 2024, meeting:

- Maria Leonard, PCC board member and proposed CharterCARE Health of Rhode Island board member;
- Dr. Louis Mariorenzi, Chief of Orthopedics at Prospect RWMC and board member of PCC; and
- Dr. Joseph Samartano, former surgeon, PCC board member, and Chair of Prospect OLF Advisory Board.

The transcript and video recording of the October 22, 2024, Council meeting may be accessed via the following links:

Transcript of the October 22, 2024 Health Services Council meeting

Video recording of the October 22, 2024, meeting of the Council

At the next meeting, held on October 29, 2024, Michael Ramey, a representative from PYA, P.C. ("PYA") and an independent consultant engaged by RIDOH, presented a summary of its observations, further delineated in its "*Summary of Observations Proposed Application Involving Prospect CharterCARE*," and Patrick S. Romano, MD, MPH, independent consultant hired by RIDOH, presented a summary of his findings and recommendations, further delineated to his "*Consulting Expert Report of Dr. Patrick Romano*."

PYA and Dr. Romano's presentations may be accessed via the following links:

Presentation of PYA's Summary of Observations Proposed Application Involving Prospect CharterCARE

Presentation of Consulting Expert Report of Dr. Patrick Romano

The opportunity for public comment was offered at the meeting, no comments were provided.

The transcript and video recordings of the October 29, 2024, Council meeting may be accessed via the following links:

Transcript of the October 29, 2024 Health Services Council meeting

Video recording of the October 29, 2024, meeting of the Council

As a result of questions from the Council during the October 22, 2024 and October 29, 2024 meetings, the Applicant provided the following supplemental documents:

- A memorandum dated October 25, 2024;
- A memorandum dated November 8, 2024; and
- Draft of Amended Bylaws for CharterCARE Health of Rhode Island, CharterCARE Health of Rhode Island Foundation, Inc., CharterCARE OLF, and CharterCARE RWMC.

Applicant's Correspondence

At the third Council meeting on November 12, 2024, the Applicant's representatives made additional comments and responded to questions from the Council on the proposal and responded to public comments.

The following individuals provided public comment during the November 12, 2024 meeting:

- Christopher Callaci, General Counsel, for the United Nurses & Allied Professionals ("UNAP").
- Greg Mercurio, Senior Vice President of Radiation Oncology, American Shared Hospital Services.

The transcript and video recording of the November 12, 2024, Council meeting may be accessed via the following links:

Transcript of the November 12, 2024 Health Services Council meeting

Video recording of the November 12, 2024, meeting of the Council

The Council provided extensive commentary on the application, both before any motion was made on the applications, and during discussion after motions were made.
Council member Maranjian made the following statement: "*concerns have been raised about, obviously, the amount of debt in this transaction and the -- I think the competence of the leadership going forward. It appears that Centurion doesn't have much experience in this area. The local leaders have worked in the hospital. They certainly have experience in providing healthcare I think from the package. I'm not an expert on this, but certainly the hospitals at least have not been, to my understanding, from reading the materials, operating*

in a, you know, profitably for -- for many years going back many years. So there are concerns there. And Centurion is a nonprofit entity. They're not placing any money in this deal. And yet they appear to be guaranteed to make -- at least get their closing cost back of about 800,000, as well as a management contract, which I know your memo had some more information on. But [I'm] considering proposing a condition that would prohibit Centurion from collecting any fees or charges of any kind from, you know, the CharterCARE until and unless it's operating in the black for about a year determined by Rhode Island Department of Health, basically to show that Centurion has as much faith in this as everyone's asking the public and -- and this committee to have that this is going to be successful." (Page 8 of the transcript.)

In response, the Applicant's counsel stated *"[t]he corporate services agreement was approved as part of the HCA, and the monthly payments provided to Centurion, which don't kick in until after a year of consummation of the transaction, are for real services provided at fair market value and provide real value to the Rhode Island hospitals."* (Pages 10-11 of transcript.)

Council Member Lang stated: *"As Emily said, there are a lot of financial concerns. I think those were really well outlined in the expert's presentation. And I think that the -- there are pieces of this transaction that really go a long way to giving this council assurances that a recovery and a turnaround are possible. I think the -- the local control on the board of directors is something I would point to, the 66.8 million, the 80 million cash through the transaction, that – that definitely goes a long way*." (Page 14 of the transcript.)

Council member Lang later commented on the composition of the board, stating: *But I'm thinking about that 40 percent number. On the one hand, I can see that it is helpful to have Centurion with a controlling membership on that board, particularly in the beginning, to affect this transition and move decisively. On the other hand, trying to take lessons learned very recently about the importance of local control and the value of local control, I'm thinking about whether that balance could be shifted over time after the initial turnaround periods, such that maybe it's more in the favor of local control over time as Centurion and the urgency of the moment fade and Centurion can, you know, ostensibly set up this local team, bring in the resources that are needed, make those initial decisions pursuant to the transition plan, and then, you know, begin to see some of that control.* (Page 40-41 of the transcript.)

Council member Walker initially moved that the applications for the hospitals be approved, and extensive deliberation followed. During these deliberations, the Council discussed the timing of appointment of the Chief Restructuring Officer ("CRO") and the CRO's participation of the transition plan, the composition of the new board of directors, and whether layoffs of employees should be prohibited for a specific time.

As to the board composition, Council member Lang stated "*So I would just move that we amend that underlying motion to require that the board configuration or the configuration of the board of governors be revisited annually with respect to the makeup of its membership, and that a report from the board be submitted to the Department of Health regarding potential plans to transition seats to independent -- to seats that would be of an independent*

nature and not employees or affiliates of Centurion. I think that that could be done annually and that there would be an expectation that after the first three years, there would be a focus on transitioning those seats to independent control. And then that would be reported on -- in that annual report from the board of governors." (Page 58-59 of the transcript.)

Council member Coia stated the following, "*[m]y concern, as I said, is with the employees. And one of the conditions to approval that was put forth by Council Callaci was to prohibit Centurion from laying off or subcontracting employees' work for a period of five years from the date of the closing of the transaction. So I think that would afford some protection to the existing employees there. Any agreements that may be in place."* (Page 65 of the transcript.)

Council member Walker provided the following response to Council member Coia's remarks: "*I understand the -- the concern about the workforce, and I also share the same concern about the financial viability. But I refer back to the last page of PYA's document, and this has been nagging in the back of my mind the whole time is that questions persist on PMH's ability and inclination to continue funding PCC operational losses, capital expenditures, and debt obligations. And then significant concerns exist with the new CharterCARE System's ability to effect this transfer and the financial improvements necessary to sustain – sustain Operations*." (Page 68 of the transcript.) A motion was made to include a condition of approval preventing layoffs, which ultimately failed.

After further discussion, Council member Maranjian made a motion to amend approval by adding a condition, that was ultimately accepted, stating: "*I'd like to amend the approval by adding a condition that commencing, I think it's like three years after the date of the closing and on an annual basis thereafter just prior to the four-year and five-year point that when I – that the Rhode Island Department of Health has the discretion to require an increase -- [], increase in the independent board representation on the board if it determined after meaningful consultation with CharterCARE that it is the best interests of the Rhode Island public for there to be that change in the control."* (Page 76 of the transcript.)

After extensive deliberation, Council member Connors made a motion to approve the applications of the two hospitals by stating, "*So based on the information on file, the witnesses that were testified here, including the consultants, I move based on my belief that they -- the applicant has met the statutory criteria regarding character, commitment, competence, standing in the community, the mission to deliver health care at both Roger Williams Medical Center and Our Lady of Fatima, formerly St. Joseph's Health Services, that the commission would report favorably on the change of effective control application subject to the conditions as set forth in the Hospital Conversion Act as amended by the parameters around future directors of the corporation.*" The Council voted that the applications for the two (2) hospitals be approved. A roll call was taken and the motion passed with a vote of six (6) in favor and one (1) opposed, subject to the applicable standard conditions, incorporation of all the conditions of RIDOH's HCA Decision and subsequent related response letters, and a condition related to composition of future boards of directors. Council member Lang made a motion to approve the applications for the other three (3)

facilities. A roll call was taken and the motion passed with a vote of six (6) in favor and one (1) opposed, subject to the applicable standard conditions.

IV. FINDINGS

Section 23-17-14.3 of the licensing statute requires the Council to consider specific review criteria in formulating a recommendation for a change in effective control. The Council's comments and findings on each of the criteria follow:

1. The character, competence, commitment, and standing in the community of the proposed owners, operators, or directors of the health care facility.

Centurion was formed as a non-profit in 1996 and claims a mission of increasing access to, and lowering costs of, healthcare. According to Centurion, this has largely been achieved through development, acquisition, and financing of healthcare facilities. Since 1996, Centurion has completed more than 20 transactions, financing 31 facilities nationwide, totaling approximately $1 billion. Under this model, Centurion consults and collaborates with charitable institutions to advance their charitable purposes. The applications include select projects that Centurion has completed. Notably, none of Centurion's projects to date include owning and operating hospitals. In fact, this transaction would be Centurion's first experience with owning and operating hospitals. Likewise, none of Centurion's principals—the only three employees of the entity—have direct experience with owning and operating acute care hospitals. At the October 22, 2024 meeting, in response to a question from Council member John Sepe about Centurion's portfolio and prior experience, Benjamin Mingle responded "*to be really transparent with you, we don't have a case that was exactly like this...[b]ut we have all those elements*." (Pages 47-48 of the transcript.)

This is a unique transaction since Centurion does not own or operate any licensed entities. As a result, the Council is unable to assess Centurion against the typical metrics, such as standing with the following groups and agencies:

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

With that said, Centurion states it has been a tax-exempt entity since 1996 and has never received any audits, inquiries, or adverse determinations with respect to its 501(c)(3) status. Additionally, Centurion represented that it has no current or impending litigation against it or its affiliates.

Centurion intends to rely on the local management team to run the day-to-day operations and decision-making of the New CharterCARE System. According to Centurion, the existing management team has sufficient expertise to mitigate risk and stabilize the New Hospitals now and carry the system into a self-sustaining model. The New CharterCARE System will be led by Jeffery Liebman, the current CEO of PCC, along with the current management team, nearly all of whom have agreed to continue in their respective roles post-closing. Jeffrey Liebman has been with PCC since 2018. At the October 22, 2024 meeting, Jeffrey Liebman stated that as a result of the proposed transaction, "*We will be repositioning ourselves to be better community citizens again"...."And we're going to reengage in community and fundraising activities. We can do more for those people in the community that are socioeconomically challenged. By going back to not-for-profit status, we can do more for them."* (Page 21-22 of the transcript.)

The Applicant stated that the licensed facilities have a long history of providing vital services to the community such as emergency medicine, behavioral health, cancer care, bariatric care, and elder care. The Applicant noted that RWMC has the state's only bone marrow transplant program and Level IV Alcohol & Drug Detoxification Program. RWMC is an academic medical center affiliated with Boston University School of Medicine. The Applicant represented that OLF has been recognized as a Patient-Centered Medical Home by the National Committee for Quality Assurance and that OLF is the state's first comprehensive wound treatment center. The Applicant further states that combined, RWMC and OLF offer the state's second largest and most comprehensive range of behavioral health services.

The Applicant's representations on this criterion can be found in its applications, its presentations, public comments supporting the applications, and the transcripts included in the links provided in section III. Introduction of this report. At the October 22, 2024, meeting, the Applicant highlighted several written comments in support of the application, including written comment from Senate President Dominick J. Ruggerio and Joseph M. Polisena, Sr., Mayor of Johnston. (Page 29-30 of the transcript; letter dated 10/21/2024.) Addressing the Council during the October 22, 2024 meeting, among other comments, Maria Leonard stated "*Culture matters. And the cultural alignment between Centurion and CharterCARE, I think -- you know, to me culture is about behaviors and actions. And how we've seen Prospect behave and act compared to just even the, you know, early indications of what Centurion brings to the table, it's a cultural fit. And it's about doing the right things for the right reasons and to support our community."* (Page 35 of the transcript.)

Dr. Mariorenzi, among other comments, stated this regarding Prospect: "*they're very good at taking the money that we generate. They are terrible at returning it to run the operations of the hospital*," and that under current ownership, "*[w]e are struggling as providers to provide the care we need. We are understaffed. We have outdated equipment. We have some broken equipment. We can't guarantee that supplies are always available. And it is getting harder and harder to be comfortable providing the care*." (Page 37 of transcript.)

Dr. Samartano, finishing his comments, stated *"In summation, The Centurion Foundation's mission will increase health care accessibility and affordability while ensuring its health care holdings through charitable endeavors in our communities. It will return CharterCARE*

to a nonprofit status allowing partnerships with key organizations to improve the health care and quality of life of all Rhode Islanders, while maintaining control of hospital through local leadership and a local board." (Pages 67-68 of the transcript.)

At the November 12, 2024 meeting, Gregory Mercurio, speaking to his experience with PCC and Centurion related to acquisition of the Radiation Therapy Centers in Rhode Island, stated "*I expressed my concerns at the time about the conditions of the – the financial conditions of the hospital, and I asked for an explanation as to what Mr. Liebman's plans were, either as CharterCARE alone or with Centurion, and he was very forthcoming, open, and honest."* Mercurio went on "*for the benefit of all the patients that we continue to treat together, I'd ask you to please vote in the affirmative today so that these patients can continue to get the high quality, compassionate care that we've been providing along with CharterCARE since 2005*." (Pages 37-39 of the transcript.)

Christopher Callaci provided lengthy written comment in opposition of the applications on November 6, 2024 and provided public comment at the November 12, 2024 meeting. Callaci stated, among other comments, "*[w]e don't question the integrity of Centurion or anything like that."* (Page 28 of the transcript).

Public comments objecting to the applications, both written and provided during the Council's meetings, are included in the links in section III. Introduction of this report.

By virtue of its vote recommending approval, the Council finds that the Applicant has met this criterion.

Finding: The Council finds that the Applicant satisfies this criterion at the time, place, and circumstances as proposed.

2. **The extent to which the facility will provide, without material effect on its viability, safe and adequate treatment for those individuals receiving the facility's services.**

   As discussed above, the total capital cost of the Proposed Transaction is $258,893,000. Approximately $192 million of that cost will be in the form of debt funds. The Applicant states that this debt will be taken on by the New CharterCARE System. As proposed, it is anticipated that the New CharterCARE System will begin operations with $80 million cash on hand, as well as the $66.8 million Hospital Fund.

   According to the Applicant, the plan of finance has been devised to set the New CharterCARE System up for success. The Applicant expects that the finance plan, along with the return to nonprofit status and the execution of the initiatives will provide long term feasibility and stability to the New CharterCARE System. The Applicant asserts the initiatives will result in a quick turnaround for the New CharterCARE System to continue providing services. The Applicant states projected financial performance for each facility for FY 2025, FY 2026, and FY 2027 as follows:

The following information is projected by the Applicant for each licensed facility in FY 2025:

CharterCARE RWMC

Total Revenues	$211,328,399
Total Expenses	$212,848,705
Operating Profit	($1,520,306)

CharterCARE OLF

Total Revenues	$170,309,718
Total Expenses	$156,555,155
Operating Profit	$13,754,563

CharterCARE BVS

Total Revenues	$2,420,857
Total Expenses	$2,420,857
Operating Profit	$ 0

CharterCARE Home Health

Total Revenues	$3,489,140
Total Expenses	$3,498,141
Operating Profit	($1)

CharterCARE Sleep Disorders Center[5]

Total Revenues	$211,328,399
Total Expenses	$212,848,705
Operating Profit	($1,520,306)

The following information is projected by the Applicant for each licensed facility in FY 2026:

CharterCARE RWMC

Total Revenues	$212,367,425
Total Expenses	$212,286,243
Operating Profit	$81,182

[5] Please note, that as the Sleep Center is part of RWMC's legal entity, its financial information is not separately tracked from RWMC. Accordingly, the RWMC information is included above.

CharterCARE OLF

Total Revenues	$171,346,962
Total Expenses	$156,027,084
Operating Profit	$15,319,878

CharterCARE BVS

Total Revenues	$2,469,274
Total Expenses	$2,469,274
Operating Profit	$ 0

CharterCARE Home Health

Total Revenues	$3,568,103
Total Expenses	$3,568,104
Operating Profit	($1)

CharterCARE Sleep Disorders Center

Total Revenues	$212,367,425
Total Expenses	$212,286,243
Operating Profit	$81,182

The following information is projected by the Applicant for each licensed facility in FY 2027:

CharterCARE RWMC

Total Revenues	$213,437,937
Total Expenses	$209,925,456
Operating Profit	$3,512,481

CharterCARE OLF

Total Revenues	$172,415,639
Total Expenses	$153,702,761
Operating Profit	$18,712,878

CharterCARE BVS

Total Revenues	$2,518,659
Total Expenses	$2,518,660
Operating Profit	$ 0

CharterCARE Home Health

Total Revenues	$3,639,464
Total Expenses	$3,639,466
Operating Profit	($2)

CharterCARE Sleep Disorders Center

Total Revenues	$213,437,937
Total Expenses	$209,925,456
Operating Profit	$3,512,481

The Applicant's representation of this criterion can be found in its applications, its presentations, public comments supporting the applications, and the transcripts included in the links provided in section III. Introduction of this report.

At the October 22, 2024 meeting, the Applicant addressed the Council regarding the financial plan for the Proposed Transaction. Benjamin Mingle stated "*We also negotiated a purchase price reduction of $80 million. And that allows us to finance the whole entire purchase price of $160 million but retain $80 million on the balance sheet of the new health systems for its, you know, firepower, or working capital or raining day fund. When you look at the national average of health systems like this, that gives us about 80 days' cash on hand, and that's around the national average for an investment grade-rated health system[].*" Benjamin Mingle went on to state that *"the hospital fund is going to go on the balance sheet of the health system, but it is going to be restricted. But that is an additional $66.8 million that will also go to support the sustainability of these organizations.* Benjamin Mingle went on to say "*there will be $130 million of cash on the balance sheet. So that's a material amount of money. We feel, you know, really good about that*." (Pages 27-28 of the transcript.)

Additionally, at that same meeting, Jeffrey Liebman stated that while it was not included in the application, the change in tax status to non-profit will expand opportunities for the New CharterCARE System to accept charitable contributions and grants, as well as reengage in community and fundraising activities, which is currently not possible under the current tax status of PCC. (Page 71-72 and 21 of the transcript.)

At that same meeting, the Applicant discussed the future viability of the New CharterCARE System, saying "[i]*n the future, our business plan that we have put together includes a $60 million financial turnaround. you can break that turnaround down into really five quadrants*" including non-profit status, growing volumes and service lines,

expense reduction, revenue cycle reimbursements, and workforce. (Pages 18-19 of the transcript.)

RIDOH engaged consulting and accounting firm, PYA, to provide observations on the financial terms of the Proposed Transaction as it relates to certain criteria under the Hospital Conversions Act, § 23-17.14-1, *et seq*. and the criteria related to the CEC review. PYA analyzed relevant information provided by the Applicants, requested and analyzed relevant supplemental information, attended meetings and statements under oath and prepared a report documenting observations.

In presenting a summary of its observations from its engagement, Michael Ramey, representing PYA, summarized the following on Page 20 of its presentation to the Council during the October 29, 2024, meeting:

• Both PCC and PMH face short-term financial viability challenges.
• Questions persist on PMH's ability and inclination to continue funding PCC operational losses, capital expenditures, and debt obligations.
• Significant concerns exist with New CharterCARE System's ability to successfully affect this transition and achieve the financial improvement necessary to sustain operations.
• Most impactful HCA Conditions of Approval aimed to mitigate concerns:

- *RIAG issued a condition of approval which required the Transacting Parties contribute $66.8 million of equity into a hospital fund – a restricted non-permanent fund for the sole benefit of the new hospitals*
- *RIDOH issued a condition of approval which required the appointment of a Chief Restructuring Officer (CRO) experienced in healthcare turnarounds*

PYA's complete summary of observations may be found in its presentation and the transcript of the October 29, 2024, meeting, included in the links provided in section III. Introduction of this report.

At the November 12, 2024 meeting, Christopher Callaci stated, "*[w]e're concerned about lack of, in our view, financial viability of this business model*." (Page 28 of the transcript.) Callaci went on to say "*we know that Prospect CharterCARE lost a $122 million over the four year period between fiscal year '20 and '23. We know that. We know, therefore, that they are in dire need of money. I don't even know if dire does it, but we'll use that term. We know that they're not getting any money from Centurion. We know that. We know that under this application, this system will take on $390 million in new debt. if you don't have the money to do the things that you need to do and you ain't going to get it done, I don't know how anybody can expect Mr. Liebman with his team or a turnaround consultant or a chief restructuring offer to be able to turn these places around without the capital they need to turn it around. And the capital is simply not there.*" (Pages 30-32 of the transcript.)

The entirety of Christopher Callaci's comment and all other public comments considered can be found within section III. Introduction of this report.

By virtue of its vote recommending approval, the Council finds that the Applicant has met this criterion.

<u>Finding:</u> The Council finds that the Applicant satisfies this criterion at the time, place, and circumstances as proposed.

3. **The extent to which the facility will provide safe and adequate treatment for individuals receiving the health care facility's services.**

The Applicant asserts that the New CharterCARE System will continue to provide high quality services to the community. Page 15 of Applicant's presentation to the Council on October 22, 2024, includes at least five initiatives related to quality, such as enhancing the star ratings at each hospital, hiring additional staff, and enhancing daily rounding activities. The presentation continued, on Page 17, stating that the entities will maintain their current quality assurance plans and within the first year, "*the New Hospitals will each establish quality committees that will review and design quality plans for the New Hospitals based on each of their unique features.*"

RIDOH engaged independent consultant Dr. Romano, and his team, to review issues of quality and safety of the hospitals as it relates to certain criteria under the Hospital Conversions Act, § 23-17.14-1, *et seq*. and the criteria related to the CEC review. Dr. Romano stated that he reviewed the HCA application and subsequent materials, analyzed public data, reviewed citations and surveys, visited and toured RWMC and OLF, as well as attended multiple meetings. Dr. Romano prepared a report detailing his findings and recommendations that was included in the HCA Decision.

Dr. Romano suggested several recommendations, provided on Page 16 of the presentation to the Council that to "*ensure that the Centurion Foundation, Inc., and the New CharterCARE System are well positioned, after the proposed conversion, to continue providing "safe and adequate treatment, appropriate access, and balanced healthcare delivery to the residents of the state,*" which include:

- *Deferred maintenance and replacement*
  - *Roof replacement*
  - *Chilling tower and cooling equipment*
  - *Imaging equipment*
- *Deficient quality improvement plans*
  - *Identify a systemwide Chief Quality Officer*
  - *Adapt Performance Improvement plans to meet the distinct needs of each hospital and its product lines*
  - *Identify updated comparative benchmarks appropriate for academically affiliated community hospitals (e.g., Vizient)*
  - *Update quality and safety indicators based on current CMS policies*
  - *Implement improvement programs for patient experience etc.*
- *Deferred purchasing of equipment and services*
  - *Upgrade EHR system to support systemwide integration, point of care data entry, and improved barcoded medication administration*
  - *Order new inpatient beds to support safer care*
- *Security*
  - *Update security management plan based on complete risk assessment*

By virtue of its vote recommending approval, the Council finds that the Applicant has met this criterion.

<u>Finding:</u> The Council finds that the Applicant satisfies this criterion at the time, place and circumstances as proposed.

4. **The extent to which the facility will provide appropriate access to traditionally under-served populations.**

The Applicant stated the licensed facilities have historically provided care to the underserved. The hospitals operate adult and geriatric psychiatric inpatient units, as well as outpatient psychiatric services that are critical components of Rhode Island's behavioral health care delivery system. In its presentation to the Council on October 22, 2024, the Applicant asserted, among other actions, that Centurion will enact an updated charity care policy that complied with Federal and State law and will continue to provide care to Medicaid and Medicare recipients at approximately the same rate currently provided.

The following payor mix is projected for CharterCARE RWMC if the proposal is approved for FY 2025:

Payor Mix	Percent
Medicare	40
Medicaid	21
Blue Cross	23
Commercial	7
HMO's	3
Self Pay	6
Other:	0
Total	**100%**

The following payor mix is projected for CharterCARE OLF if the proposal is approved for FY 2025:

Payor Mix	Percent
Medicare	45
Medicaid	19
Blue Cross	18
Commercial	8
HMO's	5
Self Pay	4
Other:	1
Total	**100%**

The following payor mix was projected for CharterCARE BVS if the proposal is approved for FY 2025:

Payor Mix	Percent
Medicare	33.1
Medicaid	8.7
Blue Cross	31.1
Commercial	18.8
HMO’s	4.1
Self Pay	3.3
Other:	0.1
Total	**100%**

The following payor mix was projected for CharterCARE Home Health if the proposal is approved for FY 2025:

Payor Mix	Percent
Medicare	83.7
Medicaid	5.7
Blue Cross	0
Commercial	3.7
HMO’s	6.2
Self Pay	0.2
Other:	0.5
Total	**100%**

The following payor mix was projected for CharterCARE Sleep Disorders Center if the proposal is approved for FY 2025:

Payor Mix	Percent
Medicare	40
Medicaid	21
Blue Cross	23
Commercial	7
HMO’s	3
Self Pay	6
Other:	0
Total	**100%**

On Page 8 of the presentation to the Council on October 29, 2024, Dr. Romano agreed that the RWMC and OLF have a high proportion of patients from traditionally underserved communities.

By virtue of its vote recommending approval, the Council finds that the Applicant has met this criterion.

Finding: The Council finds that the Applicant satisfies this criterion at the time, place, and circumstances as proposed.

V. RECOMMENDATION

After considering each of the review criteria as required by statute and the representations made by the Applicant, the Council recommends that these requests for a change in effective control be approved.

Approval and implementation of these applications will result in the termination of:

(1) the existing hospital license issued to Prospect CharterCARE RWMC, LLC d/b/a Roger Williams Medical Center and the issuance of a new hospital license to CharterCARE Roger Williams Medical Center;

(2) the existing hospital license issued to Prospect CharterCARE SJHSRI, LLC d/b/a Our Lady of Fatima Hospital and the issuance of a new hospital license to CharterCARE Our Lady of Fatima Hospital;

(3) the existing freestanding ambulatory surgery center license issued to Prospect Blackstone Valley Surgicare, LLC and the issuance of a new freestanding ambulatory surgery center license to CharterCARE Blackstone Surgery Center, LLC;

(4) the existing home nursing care provider license issued to Prospect CharterCARE Home Health and Hospice, LLC d/b/a Prospect CharterCARE Home Health and Hospice and the issuance of a new home nursing care provider license to CharterCARE Home Health and Hospice, LLC; and

(5) the existing a licensed organized ambulatory care facility license issued to Prospect CharterCARE RWMC, LLC d/b/a CharterCARE Sleep Disorders Center and the issuance of a new organized ambulatory care facility license issued to CharterCARE Roger Williams Medical Center d/b/a CharterCARE Sleep Disorders Center.

VI. CONDITIONS OF APPROVAL

The Council recommends that approval of the instant applications shall be subject to the following conditions:

1. that the applications be implemented as approved;

2. that data, including but not limited to, finances, utilization, and demographic resident information, be furnished to the state agency, upon request;

3. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center maintain accreditation from a nationally recognized accrediting agency;

4. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center shall conduct national criminal background checks on their employees prior to employment;

5. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center establish and put into effect formal agreements for referral of charity care cases with a minimum of one 501(c)(3) licensed community health center in their service areas within sixty (60) days of approval;

6. that CharterCARE BVS, CharterCARE Home Health, and CharterCARE Sleep Disorders Center cooperate with 501(c)(3) providers who refer clients for charity care services to the Applicant's facilities to pre-certify such referred individuals to qualify for charity care services at the Applicant's facilities;

7. for the CharterCARE RWMC and CharterCARE OLF applications, that the Applicant comply with all applicable conditions as set forth in RIDOH's HCA Decision, dated June 20, 2024, and RIDOH's subsequent related response letters; and

8. that three (3) years after the date of the closing of the Proposed Transaction and on an annual basis thereafter for an additional two (2) years, the Applicant will submit a written report, including any proposed reconfiguration of the composition of the boards of directors and, at RIDOH's discretion, increase the percentage of independent (i.e., not employed by or affiliated with, Centurion or its affiliates) board representation.

Appendix B

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November 21, 2024

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Providence, RI 02908
jerome.larkin@health.ri.gov

Re: Report of the Health Services Council on the Applications of the Centurion Foundation, Inc., Sole Member of CharterCare Health of Rhode Island, Inc., Sole Member of CharterCare Roger Williams Medical Center, CharterCare Our Lady of Fatima Hospital, CharterCare Blackstone Surgery Center, LLC, CharterCare Home Health And Hospice, LLC, CharterCare Roger Williams Medical Center d/b/a CharterCare Sleep Disorders Center for Changes in Effective Control of Prospect CharterCare RWMC, LLC d/b/a Roger Williams Medical Center Prospect CharterCare SJHSRI, LLC d/b/a Our Lady of Fatima Hospital; Prospect Blackstone Valley Surgicare, LLC d/b/a Blackstone Valley Surgicare; Prospect CharterCare Home Health and Hospice, LLC d/b/a Prospect CharterCare Home Health and Hospice; and Prospect CharterCare RWMC, LLC d/b/a CharterCare Sleep Disorders Center (the "HSC Report")

Dear Dr. Larkin:

I am an attorney with Hall, Render, Killian, Heath & Lyman, P.C. serving as transaction counsel to The Centurion Foundation, Inc. ("Centurion") in connection with the Prospect CharterCare transaction that is the subject of the above-referenced HSC Report. I was not able to attend the November 19, 2024 HSC meeting; however, I have reviewed the transcript and the HSC Report. I am writing to you regarding proposed Condition of Approval 8 in the HSC Report which provides:

> that three (3) years after the date of the closing of the Proposed Transaction and on an annual basis thereafter for an additional two (2) years, the Applicant will submit a written report, including any proposed reconfiguration of the composition of the boards of directors and, at RIDOH's discretion, increase the percentage of independent (i.e., not employed by or affiliated with, Centurion or its affiliates) board representation.

For the reasons set forth below Centurion is requesting that RIDOH modify Condition 8 as follows, consistent with Condition of Approval 12 in the RIDOH HCA Decision regarding Board composition:

> *That three (3) years after the date of the closing of the Proposed Transaction and on an annual basis thereafter for an additional two (2) years, the Applicant will submit a written report, including any proposed reconfiguration of the composition of the Board of Directors and by agreement of the Applicant and RIDOH, the percentage of independent (i.e., not employed by or affiliated with, Centurion or its affiliates) Board representation, may increase.*

First, as you know, RIDOH clarified Condition 12C regarding the percent of independent directors by reducing the original requirement in the June 20, 2024 HCA Decision of 67% to 40%, after productive meetings with your staff explaining the need for Centurion to retain ultimate control. Specifically, we explained that as the sole member of CharterCare Health of Rhode Island, Inc., Centurion needs to retain ultimate control in order to ensure that the New CharterCARE System (1) operates consistently with Centurion's mission and tax exempt status and (2) complies with the Conditions of Approval in RIDOH's HCA Decision.[1] Without such control it would have been possible that a Board comprised of 67% independent members could take actions that would negatively impact Centurion's mission and tax-exempt status or more importantly be adverse to the HCA Conditions of Approval. A Board with 40% independent directors will ensure that independent community representation is preserved while at the same time Centurion will be in a position to ensure compliance with all of the HCA Conditions of Approval. In addition, the 40% requirement is consistent with the Rhode Island Attorney General HCA Condition of Approval regarding Board composition. Proposed Condition 8 in the HSC Report is inconsistent with RIDOH's HCA Condition of Approval regarding Board composition as it provides unilateral discretion to RIDOH in years 4 and 5 post-closing to change the independent board representation jeopardizing Centurion's status to retain ultimate control consistent with its status as the sole member of CharterCARE Health of Rhode Island.

Second, and equally as important, proposed Condition 8 presents an uncertainty regarding the composition of the Board in the future and such uncertainty must be disclosed to investors of the bonds. As you know, this transaction will be financed through the issuance of bonds by RIHEBC. The inconsistency and uncertainty resulting from proposed Condition 8 is a material change that could adversely impact the bond financing and consummation of the transaction.

Finally, the Centurion Board of Directors approved this transaction back in 2022, but because of the changes imposed by the RIAG and RIDOH HCA Conditions of Approval, the Centurion Board must review and reaffirm its support for the transaction prior to Closing. As transaction counsel to Centurion, I cannot recommend that the Centurion Board approve the Transaction

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[1] Such conditions include, without limitation using best efforts to ensure compliance with Conditions 11 (payroll obligations, taxes, debt servicing, vendor payments and the like), 31 (PACE obligations) and other required annual payment and performance conditions.

when this proposed HSC condition puts in doubt Centurion's ability to ensure compliance with the HCA Conditions.

While Centurion values the input of independent directors and appreciates the intent of the Council members in proposing Condition 8, the way it is currently written requires modification to ensure (1) Centurion meets all Conditions of Approval and (2) there is no jeopardy to the issuance of bond financing in order to ensure consummation of the transaction which will result in the preservation of two very important community hospitals providing quality services to the communities they serve.

We respectfully submit that the proposed modification to Condition 8 set forth above achieves all objectives including preserving the importance of independent directors. Accordingly, we request that you adopt the HSC Report but modify proposed Condition 8. Thank you for your consideration and if you have any questions, please contact me.

Sincerely,

HALL, RENDER, KILLIAN, HEATH & LYMAN, P.C.

Charles P. Sukurs

CPS/pm

Appendix C

RI Department of Health

License Application and instructions for

HOSPITALS

RI General Laws Chapter 23-17-10

Licensee Name: ____

Licensee Number: ____

Reason for application (Please check all that apply):

1. Initial Licensure
2. Change of address - current license number:________________________
3. Change of ownership - current license number:_____________________
4. Licensee Name Change to:_______________________________________

State of Rhode Island
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ball point pen.

- Each application shall be accompanied by a non-refundable, non-returnable application fee of sixteen thousand nine hundred dollars ($16,900.00) per facility plus an additional fee of one hundred twenty dollars ($120.00) per licensed bed, made payable to the ***Rhode Island General Treasurer***.

- Sign the completed application and return to:
  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the office of Facilities Regulations at (401) 222-2566.

- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach:

a. A current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership for the licensed entity and any parent organization or affiliation. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

b. For Initial:
   i. By-Laws of the Corporation;
   ii. By-Laws of the Medical Staff;
   iii. Check for appropriate license fee.
   iv. Signed agreements for all contracted services

c. For Renewal - (If no amendments were made in the last year, please include a statement to that effect with application):
   i. Amendments to By-Laws of the Corporation;

d. Amendments to By-Laws of the medical staff;

e. The most recent Hospital Annual Report; N/A for Initial

f. A copy of accreditation approval (i.e., TJC, CARF, AOA) and/or accreditation inspection report (If no changes/inspections/correspondence regarding your accreditation since the last renewal, please include a statement to that effect with application);

g. A copy of the most recent CAP report;

h. Check for appropriate license fee.

i. For Change of Address:
   i. Local municipality planning board/zoning approval;
   ii. State Fire Marshall's Office/local fire authority occupancy approval;

Attachments: Any/all attachment(s) with this application must be labeled and stapled separately and securely affixed to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

State of Rhode Island
Department of Health

Please complete the following:

Federal Provider Number: (Leave blank if N/A)	Federal Provider Number: ______
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
If charitable institution/nonprofit, please complete the following:	**Date established:** ______ **Special Charter: Yes** ______ **No** ______
Type of Hospital (Please select one)	**General Hospital** ______ **Specialty** ______
Compliance with Conditions of Approval (Please check yes or no).	**This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Con trol, Initial Licensure and/or Licensure renewal).** **Yes** ______ **No** ______
Facility Name: Please provide the name of the facility (as known to the public).	Name: ______
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: ______ Phone Number: ______
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on RIDOH website**).	Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Address Country ______ Phone: ______ Fax: ______ Email Address: ______

State of Rhode Island
Department of Health

Facility Location Information: Please provide the location information for this facility. (**Published on RIDOH website**).	Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Address Country ______ Phone: ______ Fax: ______ Email Address: ______
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: (Licensee) Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: ______ (License Holder) DBA: ______ Contact person: ______
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address ______ Address ______ Address ______ City and State, ______ Zip Code ______ Phone: ______ Fax: ______ Email Address: ______

State of Rhode Island
Department of Health

Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type ______ Contact person ______ Nameof Organization ______ Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ City, State, Zip Code ______ Phone: ______ Fax: ______ Email Address: ______
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: ______ Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ City, State, Zip Code ______ Phone : ______
Accreditation (Please complete for all that apply.	**TJC** ______**Yes** ______ **No** **Date of survey** ______ **Term of accreditation** ______**years** **AOA** ______ **Yes** ______**No** **Date of survey** ______ **Term of accreditation** ______**years** **CARF** ______**Yes** ______**No** **Date of survey** ______ **Term of accreditation** ______**years** **CAP** ______ **Yes** ______**No** **Date of survey** ______ **Term of accreditation** ______**years**
Does the hospital have a PPS excluded Psychiatric Unit?	**Yes** ______ **No** ______ **If yes, please complete the following:** **Related Provider Number:** ______ **Number of beds:** ______
Does the hospital have a PPS excluded Rehabilitation Unit?	**Yes** ______ **No** ______ **If yes, please complete the following: Related Provider Number:** ______**Number of beds:** ______
Does the hospital have a federal certification as a Psychiatric Hospital?	**Yes** ______ **No** ______ **If yes, please complete the following: Federal Provider Number:** ______**Number of beds:** ______
Does the hospital offer Stroke Prevention and Treatment services?	**Yes** ______ **No** ______

State of Rhode Island and
Department of Health

Does the hospital provide tertiary care?	**Yes** ______________ **No** ______________		
Bed Capacity and Complement as of: ________________ (Please complete the following sections relative to the hospital's licensed bed capacity and number of beds actually in use)	**I. Adult Medical Surgical Beds**	**# of Beds Licensed**	**# of beds in use**
	A. ICE/CCU	________	________
	B. Short Term	________	________
	C. Long Term	________	________
	D. Substance Abuse	________	________
	E. Cooperative Care	________	________
	F. Total (Sum of A-E)	________	________
	II. Obstetrics Beds	________	________
	III. Pediatric Beds		
	A. ICU	________	________
	B. Short Term	________	________
	C. Long Term	________	________
	D. Total (Sum of A-C)	________	________
	IV. Psychiatric Beds		
	A. Intensive	________	________
	B. Short Term	________	________
	C. Long Term	________	________
	D. Forensic		
	E. Total (Sum of A-C)		
	V. Rehabilitation Beds	________	________
	VI. Other inpatient (Please list specific catagory)		
	A. ______________________________	________	________
	B. ______________________________	________	________
	C. ______________________________	________	________
	D. **Total (Sum A-C)**	________	________
	VII. Total Beds (Sum of I-F, II, III-D, IV-DE, V and VI-D)	________	________
	VIII. Bassinets	________	________
	Please attach a listing of the licensed bed capacity by hospital unit. Also indicate beds in use (equal to or less than the licensed capacity) by Hospital Unit.		

State of Rhode Island
Department of Health

<table>
<tr><td>Please identify the number of Emergency Department Treatment stations/stretchers/beds.</td><td>A. General treatment ___________
B. Cardiac ___________
C. Trauma ___________
D. Orthopedic ___________
E. OB/GYN ___________
F. Observation (if separately designated) ___________
G. Urgent Care/Express/Fast Track ___________
H. Other (please specify):
a. ___________
b. ___________
c. ___________

I. Total (Sum of A-H)</td></tr>
<tr><td>Total number of Hospital Premises:
______________________</td><td>Please identify all <u>premises</u> covered by the Hospital License, the name by which each is known, its certificate number, the services provided, and whether or not the premises were reviewed during your last Accreditation Survey. The first premises listed should be the main hospital building (or campus). Be sure to list <u>all</u> premises, including off-campus labs and drawing stations. (Add additional sheets as needed).</td></tr>
</table>

Premises Name ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________________Fax:__________________________E-mail:__________________________

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

State of Rhode Island
Department of Health

Premises Name____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________________Fax:__________________________E-mail:______________________________

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

Premises Name ____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________________Fax:__________________________E-mail:______________________________

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

Premises Name ____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________________Fax:__________________________E-mail:____

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

Premises Name____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________________Fax:__________________________E-mail:____

Name of contact person: ____
Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

State of Rhode Island
Department of Health

Premises Name ____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________Fax:______________E-mail:______________________

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

Premises Name____

Premises Certificate Number: ____

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code ____

Phone : ____________Fax:______________E-mail:______________________

Name of contact person: ____

Days/Hours of operation: ____

Service(s) provided: ____

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code ____

State of Rhode Island
Department of Health

Premises Name____

Premises Certificate Number: ______________________________

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code _____________________________

Phone : ______________Fax:__________________E-mail:________________________

Name of contact person: ___________________________________

Days/Hours of operation: __________________________________

Service(s) provided: ______________________________________

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code _____________________________

Premises Name____

Premises Certificate Number: ______________________________

Address Line 1 ____

Address Line 2 ____

Address Line 3 ____

Address City, State, Zip Code _____________________________

Phone : ______________Fax:__________________E-mail:________________________

Name of contact person: ___________________________________

Days/Hours of operation: __________________________________

Service(s) provided: ______________________________________

____

____

Reviewed during last Accreditation Survey? ___________Yes ___________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ____

Address: ____

Address City, State, Zip Code _____________________________

State of Rhode Island
Department of Health

Premises Name______________________________

Premises Certificate Number: ______________________________

Address Line 1 ______________________________

Address Line 2 ______________________________

Address Line 3 ______________________________

Address City, State, Zip Code ______________________________

Phone : _______________Fax:_______________E-mail:______________________________

Name of contact person: ______________________________

Days/Hours of operation: ______________________________

Service(s) provided: ______________________________

Reviewed during last Accreditation Survey? ____________Yes ____________No

If the owner of the land and building is other than the operator of the facility, please complete the following:

Name of Owner: ______________________________

Address: ______________________________

Address City, State, Zip Code ______________________________

Please list all laboratories (name, address, CLIA # and RI License number) to which the hospital refers tests:
(Add additional sheets as needed).

Lab Name: ______________________________

Address: ______________________________

Address City, State, Zip Code ______________________________

CLIA #: ____________________ RI License #______________________________

Lab Name: ______________________________

Address: ______________________________

Address City, State, Zip Code ______________________________

CLIA #: ____________________ RI License #______________________________

Lab Name: ______________________________

Address: ______________________________

Address City, State, Zip Code ______________________________

CLIA #: ____________________ RI License #______________________________

State of Rhode Island
Department of Health

Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________
Lab Name: ____________________ Address: ____________________ Address City, State, Zip Code ____________________ CLIA #: ____________ RI License #____________

State of Rhode Island
Department of Health

Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below SSN/FEIN for this license: SSN/F.E.I.N. Number: ______________________________
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** ______________________________ **Signature of Authorized Person** **Date of Signature** (MM/DD/YY) ______________________________ **Printed Name of Authorized Person** **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.**

RI Department of Health

License Application and instructions for

Freestanding Ambulatory Surgical Center

RI General Laws Chapter 23-17-10

Licensee Name: ____

Licensee Number: ____

Reason for application (Please check all that apply):

1. ☐ Initial Licensure
2. ☐ Change of address: What is your current license number:___________
3. ☐ Change of ownership: What is your current license number:___________
4. ☐ Licensee Name Change

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ball point pen.
- There is no fee for this application.
- Sign the completed application and return to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097.

- If you have any questions concerning this application, call the office of Facilities Regulations at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following:

Federal Provider Number: (Leave blank if N/A)	Federal Provider Number: ______________________
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Medical Director Information: Please provide the name of the Medical Director for this facility. **NOTE: This section must be completed as a requirement of your license renewal.**	Name: ______________________ License Number: ______________________

State of Rhode Island and Providence Plantations

Department of Health

Facility Name: Please provide the name of the facility (as known to the public).	Name: ________
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: ________ Phone Number: ( ) ________
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 ________ Address Line 2 ________ Address Line 3 ________ Address City, State, Zip Code ________ Address Country ________ Phone: ________ Fax: ________ Email Address: ________
Facility Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 ________ Address Line 2 ________ Address Line 3 ________ Address City, State, Zip Code ________ Address Country ________ Phone: ________ Fax: ________ Email Address: ________
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: (Licensee) Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: ________ (License Holder) DBA: ________

State of Rhode Island and Providence Plantations
Department of Health

<table>
<tr><td>Ownership Address Information:

Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</td><td>Address Line 1 ____
Address Line 2 ____
Address Line 3 ____
Address City, State, Zip Code ____
Phone: ____
Fax: ____
Email Address: ____</td></tr>
<tr><td>Parent Organization, Group Affiliation:

Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control</td><td>Corporation Type ____
Name of Organization ____
Address Line 1 ____
Address Line 2 ____
Address Line 3 ____
Address City, State, Zip Code ____
Phone: ____
Fax: ____
Email Address: ____</td></tr>
<tr><td>Land/Building Info:

If the owner of the land and building is other than the operator of this agency/facility, please complete the following:</td><td>Name: ____
Address Line 1 ____
Address Line 2 ____
Address Line 3 ____
Address City, State, Zip Code ____
Phone : ____</td></tr>
<tr><td>Number of Operating Rooms:
(Please write the number of operating rooms in your facility)</td><td>Number of Operating Rooms:
[ ][ ][ ][ ][ ]</td></tr>
<tr><td>Number of Recovery Beds:
(Please write the number of treatment stations in your facility)</td><td>Number of Recovery Beds:
[ ][ ][ ][ ][ ]</td></tr>
<tr><td>Services Provided:

Please check which services are provided in your facility.</td><td>Surgical:
_____ Orthopedic
_____ Plastic
_____ Urology
_____ Ear, Nose and Throat
_____ Ophthalmology
_____ Other: List Additional Services
____

Non-Surgical:
______ Radiology
______ Nursing Services
______ Anesthesia
______ Conscious Sedation
______ Laboratory
______ Other: List Additional Services
____________________</td></tr>
</table>

State of Rhode Island and Providence Plantations

Fgrctvo gpv'qh'J gcnvj

Acknowledgements

Kco "cy ctg"qh"Ej cr vgt"45/39/32"qh"vj g"I gpgtcn"Ncy u"qh"Tj qf g"Kncpf ."3; 78."cu"co gpf gf ."cpf "vj g"uvcpf ctf u."twngu"cpf "tgi wncvkqpu" r tguetkdgf "vj gtgwpf gt."y j kej "tgi wncvg"vj g"qr gtcvkqp"qh"vj ku"hcekrkv{0"

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FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Rngcug"r tqxkf g"dgmqy "UUP IHGKP "hqt"vj ku"nkegpug<" UUP IHGKP 0P wo dgt<"" ______________________________
Affidavit of Applicant Tgcf ."uki p."cpf "f cvg"vj ku" chhkf cxkv0"	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this** **Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** ______________________________ ______________________________ **Signature of Authorized Person** **Date of Signature (MM/DD/YY)** ______________________________ **Printed Name of Authorized Person** ______________________________ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.**

RI Department of Health

License Application
and instructions for

Home Nursing Care Provider

RI General Laws Chapter 23-17-10

Licensee Name: ____

Licensee Number: ____
Current RIDOH assigned license number (Leave blank if initial application)

Reason for application (Please check all that apply):

1. ☐ Initial Licensure

2. ☐ Change of address: What is your current license number:___________

3. ☐ Change of ownership: What is your current license number:___________

4. ☐ Licensee Name Change

Complete the following for either 2, 3, or 4:

Current Program Name: ___________________________ License #____________

Current Address: ____

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ball point pen.
- The fee for this application is $650. If this application reflects a change of location, there is no fee.
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application and return to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097.

- If you have any questions concerning this application, call the Center of Health Facilities Regulations at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- Provider is required to comply with all licensure requirements per the regulation 216-RICR-40-10-17, Licensing Home Nursing Care Providers and Home Care Providers, found here: https://rules.sos.ri.gov/regulations/Part/216-40-10-17.

You must attach the following items before a license can be issued:

1. A list of all direct and indirect owners, whether individual partnership, limited partnership, limited liability company, corporation with percent of ownership. If corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.
2. Members of the governing body, if different from item 2.
3. Copies of the required liability and bonding insurance in accordance with section 17.5.1(C)(2) of the regulation.
4. Copy of the criminal record check policy/procedure, in accordance with section 17.5.3(L) of the regulation.
5. A copy of reporting abuse and neglect policy/procedure, in accordance with section 17.5.1(J) of the regulation.
6. Name and credentials of the Administrator and/or Director of Nursing in accordance with section 17.5.1(B)(1) of the regulation.
7. A list of the range of services to be provided in accordance with section 17.5.1(B)(2) of the regulation.
8. A copy of the written plan for implementation of Quality Improvement Program in accordance with section 17.5.1(E)(2) of the regulation.
9. A copy of the in-service educational program in accordance with section 17.5.3(D) of the regulations.
10. A copy of the policy for supervision of nursing assistants and homemakers in accordance with sections 17.6.6(B) and 17.5.3(H) of the regulations.
11. A copy of the policy for verification of homemaker training and list of homemaker duties in accordance with section 17.5.3(I) and (J) of the regulations.
12. A copy of admission packet including advertising materials.
13. A copy of emergency preparedness plan in accordance with section 17.5.1(G) of the regulations.
14. A copy of all contracts with outside vendors who will provide medical services (e.g., physical therapy, occupational therapy etc.).
15. A list of the members of the Professional Advisory Committee in accordance with section 17.8.1 of the regulations.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the following information:

HAA Provider Number: (If your agency is certified as a Home Health Agency please provide your Federal Provider number. Leave blank if N/A.)	HHA Provider Number: ______________________________
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Compliance with Conditions of Approval Please check yes or no.	This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☐ Yes ☐ No
Agency Name: Please provide the name of the agency (as known to the public).	Name: ______________________________
Agency Contact Person: Please provide the name and telephone number of a person we can contact concerning this agency.	Name: ______________________________ Phone Number: ______________________________
Agency Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1: ______________________________ Address Line 2: ______________________________ Address Line 3: ______________________________ Address City, State, Zip Code: ______________________________ Address Country: ______________________________ Phone: ______________________________ Fax: ______________________________ Email Address: ______________________________
Agency Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1: ______________________________ Address Line 2: ______________________________ Address Line 3: ______________________________ Address City, State, Zip Code: ______________________________ Address Country: ______________________________ Phone: ______________________________ Fax: ______________________________ Email Address: ______________________________

Branch Office Information:	Home Nursing Care Providers operating under a single license may establish branch offices under that same single license. To establish a branch office, you must provide all of the information requested. If you have more than one branch office, please copy this section as needed and attach to this application. Branch Type: (Please select one) ☐ Home Nursing Care ☐ Home Care Branch Contact Name: ______ Address Line 1: ______ Address Line 2: ______ Address Line 3: ______ Address Line 4: ______ Phone Number: ______

Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: ______ DBA: ______
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1: ______ Address Line 2: ______ Address Line 3: ______ Address City, State, Zip Code: ______ Phone: ______ Fax: ______ Email Address: ______

Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type: ____ Name of Organization: ____ Address Line 1: ____ Address Line 2: ____ Address Line 3: ____ Address City, State, Zip Code: ____ Phone: ____ Fax: ____ Email Address: ____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: ____ Address Line 1: ____ Address Line 2: ____ Address Line 3: ____ Address City, State, Zip Code: ____ Phone: ____

Region/Geographic Area: (Please check all areas to be served)	☐ Washington ☐ Newport ☐ Bristol ☐ Providence ☐ Kent

Services Provided:

Please check which services are provided by your employees or through written agreement with others.

	By Employees	Per Agreement	Not Provided
Nursing Care:	☐	☐	☐
Physical Therapy:	☐	☐	☐
Occupational Therapy:	☐	☐	☐
Speech Therapy:	☐	☐	☐
Home Health Aide:	☐	☐	☐
Medical Social Work:	☐	☐	☐
Homemaker:	☐	☐	☐

Other: List Additional Services: ____

Homemaker Training Program:	Do you provide a Homemaker Training Program? ☐ Yes ☐ No If Yes, please attach the following information: 1. Credentials/resume of individual providing training. 2. Curriculum for Homemaker Training Program 3. Copy of final exam 4. Sample of any certificate to be awarded.

Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

<table>
<tr>
<td rowspan="2">FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.</td>
<td>Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license</td>
</tr>
<tr>
<td>SSN/F.E.I.N. Number: ____</td>
</tr>
<tr>
<td>Affidavit of Applicant

Read, sign, and date this affidavit.</td>
<td>AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

____ ____________________________
Signature of Authorized Person Date of Signature (MM/DD/YY)

____________________________ ____________________________________
Printed Name of Authorized Person Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.</td>
</tr>
</table>

RI Department of Health

License Application and instructions for

Organized Ambulatory Care Facility

RI General Laws Chapter 23-17-10

Licensee Name: ____

Licensee Number: ____

Reason for application (Please check all that apply):

1.☐ Initial Licensure

2.☐ Change of address: What is your current license number:___________

3.☐ Change of ownership: What is your current license number:___________

4.☐ Licensee Name Change

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Mark "NA" for questions that are "Not Applicable". Incomplete forms will not be processed and your license will not be issued. Please use a ball point pen.
- The fee for this application is $650 for profit. Only one $650 fee is required for non-profit with multiple locations. Non-profit charitable community health centers are exempt from this fee.
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application, return it with the required fee and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this renewal application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- **Other requirements required prior to approval:**
  - State Fire Marshall's Life/ Fire Safety approval
  - Construction requirements (Architect certification letter and floor plan) **Per 216-RICR-40-10-3 §Section 3.7.1B**
  - Certificate of Occupancy from local municipality

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please complete the information below:

Medical Director Information: Please provide the name of the Medical Director for this facility. **NOTE: This section must be completed as a requirement of your license renewal.**	Name: ____________________ License Number: ____________________
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Compliance with Conditons of Approval Please check yes or no.	This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☐ Yes ☐ No

State of Rhode Island and Providence Plantations
Department of Health

Facility Name: Please provide the name of the agency (as known to the public) for which you are applying for licensure.	Name: ______
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this agency.	Name: ______ Phone Number: ______
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Address Country ______ Phone: ______ Fax: ______ Email Address: ______
Facility Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Address Country ______ Phone: ______ Fax: ______ Email Address: ______
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: ______ DBA: ______

Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Phone: ______ Fax: ______ Email Address: ______
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type ______ Name of Organization ______ Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Phone: ______ Fax: ______ Email Address: ______
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: ______ Address Line 1 ______ Address Line 2 ______ Address Line 3 ______ Address City, State, Zip Code ______ Phone ______
Community Health Center:	Community Health Center Is your facility designated as a non-profit charitable Community Health Center? Yes ☐ No ☐
Services Provided: (Please check which services are provided by your employees or through written agreement with others.	☐ General Medical Services ☐ Laboratory Services ☐ MRI Services ☐ Radiology Services ☐ Dental Services ☐ Other: List Additional Services ______ ______ ______

State of Rhode Island and Providence Plantations
Department of Health

Acknowledgements

I am aware of Chapter 23-17-10 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below SSN/FEIN for this license: SSN/F.E.I.N. Number: ____________________
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** ____________________ ____________________ **Signature of Authorized Person** **Date of Signature (MM/DD/YY)** ____________________ **Printed Name of Authorized Person** ____________________ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended.**