Lifespan

Strategic Planning & Analysis

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Rachel M. Schwartz
Vice President

February 2, 2012

Valentina D. Adamova, MBA
(Acting) Chief Health Program Evaluator
Office of Health Systems Development
Rhode Island Department of Health
3 Capitol Hill, Cannon Building, Room 404
Providence, RI 02908

Dear Ms. Adamova:

Attached in response to your January 19 letter are twenty-five (25) copies each of the responses to the deficiencies and the revised Rhode Island Hospital (RIH) Certificate of Need (CoN) application for the acquisition of a MRI to be sited in the RIH Emergency Department. Note that the CoN reflects the responses to the January 19 deficiencies. An electronic version of these documents has also been sent to your office.

Any questions you have may be directed to Mr Russell Gross on 444-7423 or rgross@lifespan.org, as well as to ne on 444-7526 or rschwartz@lifespan.org

Sincerely,

Rachel Schwartz
Vice President

Attachments

Deficiencies: Rhode Island Hospital (MRI CON)

1. Question #1, please identify the change in annual ED visits in Rhode Island as a whole and at Rhode Island Hospital specifically in 2010 and 2011.

   The response to Question #1 has been revised to include the following - "ED visits in Rhode Island decreased from 491,693 in FY'10 down to 483,842 in FY'11, a decrease of 7,851 visits. RIH ED visits, however, increased slightly from 147,974 (96,969 adult and 51,005 pediatric) in FY'10 to 148,632 (99,294 adult and 49,338 pediatric) in FY'11, an increase of 658 visits (an increase of 2,325 adult and a decrease of 1,667 pediatric)."

2. Question #7 A, please answer the question being asked. Please complete the table and identify all the requested information in the table.

   The beginning of the response to Question #7A has been modified as follows:

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

   The applicant completed the table below working from the Department's last MRI study in the 2005/2006 time frame, calling each provider to verify the number of MRI units and making changes where necessary. While the applicant can attest that the information in the table below is accurate, it may not be complete as the applicant does not have access to information regarding any other MRI providers in the state. In addition, the applicant is not aware of any <u>documented</u> availability and accessibility problems in the state other that at its own sites, and was not able to obtain this information for other providers.

Name of Facility/Service Provider	List similar type of Service/ Equipment*	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)
Kent	1	?	?	10
Landmark	1	?	?	16
Memorial	1	?	?	6
Miriam	1	N	N	4
Newport	1	N	N	37
Rhode Island	3	N	N	0
Roger Williams	1	?	?	3
South County	1	?	?	30
St Joseph	1	?	?	7
Westerly	1	?	?	46
Women and Infants	1	?	?	0
Bristol County Open MRI Services, Inc	1	?	?	17
Nate Whipple Radiology, Lincoln	1	?	?	16
Open MRI of New England, N Smithfield	1	?	?	17

Name of Facility/Service Provider	List similar type of Service/ Equipment*	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)
Open MRI of New England, Warwick	2	?	?	9
Open MRI of New England, Cumberland	2	?	?	15
Open MRI of New England, Providence	1	?	?	3
Open MRI of New England, E Providence	1	?	?	3
Open MRI of New England, Westerly	2	?	?	44
Rhode Island Medical Imaging, Providence	2	?	?	3
Rhode Island Medical Imaging, E Providence	1	?	?	3
Rhode Island Medical Imaging, E Greenwich	1	?	?	15
Rhode Island Medical Imaging, Pawtucket	1	?	?	6
Rhode Island Medical Imaging, Lincoln	1	?	?	9
The Imaging Center, Cranston	2	?	?	4
The MRI Center, Johnston	1	?	?	7
Toll Gate Radiology, Inc, Warwick	1	?	?	12
XRA Medical Imaging, Cranston	1	?	?	4
XRA Medical Imaging, Johnston	1	?	?	7
XRA Medical Imaging, Middletown	1	?	?	26
XRA Medical Imaging, Wakefield	1	?	?	33
XRA Medical Imaging, Warwick	1	?	?	12
Newport Hospital Portsmouth Imaging Ctr.	1	N	N	32

***All MRI's**

3. Question #7 B; please answer the question being asked. Please discuss the extent to which the proposed service or equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment, including those identified in response to Question #7 A.

   The response to Question #7B has been amended with the following language at the beginning of the response - "The proposed equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment due to the unique use of the existing MRI units at RIH as described below, and because the proposed equipment will be utilized primarily for patients coming to the only Level 1 Trauma Center in the state who require an MRI."

4. Question #7 E; please clarify whether the information provided is for MRI scans conducted for ED patients. If not, please additionally provide information for those MRI scans performed for ED patients only.

   The information provided is for all MRI scans conducted at RIH, and the response to Question #7E has been revised to clarify this. In addition, a second table has been added to the response to reflect scans done for ED patients only as follows:

RIH MRI Imaging (ED Patients Only)

Actual (last 3 years)	FY **2009**	FY **2010**	FY **2011**	FY **2012**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**953**	**1,200**	**1,415**	**1,900**
Throughput Possible (#) Exams	**21,424**	**22,291**	**23,157**	**23,157**
Utilization Rate (%) Exams	**4.4%**	**5.4%**	**6.1%**	**8.2%**
Operational Utilization Rate (%) Exams*	**N/A**	**N/A**	**N/A**	**N/A**
Utilization (#) Days**	**N/A**	**N/A**	**N/A**	**N/A**
Throughput Possible (#) Days	**N/A**	**N/A**	**N/A**	**N/A**
Utilization Rate (%) Days	**N/A**	**N/A**	**N/A**	**N/A**

Projected	FY **2013**	FY **2014**	FY **2015**	FY **2016**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**2,870**	**4,209**	**4,416**	**4,633**
Throughput Possible (#) Exams	**28,981**	**30,923**	**30,923**	**30,923**
Utilization Rate (%) Exams	**9.9%**	**13.6%**	**14.3%**	**15.0%**
Operational Utilization Rate (%) Exams*	**N/A**	**N/A**	**N/A**	**N/A**
Utilization (#) Days**	**N/A**	**N/A**	**N/A**	**N/A**
Throughput Possible (#) Days	**N/A**	**N/A**	**N/A**	**N/A**
Utilization Rate (%) Days	**N/A**	**N/A**	**N/A**	**N/A**

5. Question #23, when answering this question, please discuss the impact of the $2.5 + million in projected revenue as a cost to the healthcare system in general and to the publicly funded healthcare specifically.

The response to Question #23 has been revised to add the following:

The projected net revenue of approximately $2.5 million represents a negligible (less than 1/10 of 1%) change in healthcare cost spending across the 10 acute care hospitals in the state of Rhode Island (based on 2010 figures, HARI).

Relative to the state's publicly funded portion of healthcare costs, the Medicaid net revenue of $18,000 (See response to Question #19) associated with providing an additional 68 MRI exams to Medicaid patients (See table below) represents less than 1/1000 of 1% of Medicaid's total medical expense spending (based on SFY 2010 Rhode Island Annual Medicaid Expenditure Report, Executive Office of Health and Human Services June 2011).

It should be noted that this incremental impact is associated with providing 1,133 net incremental MRI exams, and replacement of 2,000 existing CT scans projected to be replaced by MRI exams. It is believed that these exams and associated cost will ultimately be provided, whether at RIH or some other facility and potentially with the same delays currently experienced by people coming to the RIH ED who require an MRI exam, independent of locating an MRI unit in RIH ED.

In attempting to answer the question of whether or not this increased cost is "worth it", an article

titled, "How Changes in Medical Technology Affect Health Care Costs" suggests that it is not possible to measure the direct effect of spending associated with advancing technology. There are simply too many variables and they interrelate in such a way that makes it impractical to determine the cost. Another article titled "Improving Patient Care Through Early Health", says the use of advanced radiology technology allows for complete diagnosis of trauma victims within 3 hours of arrival, avoids unnecessary surgery in many cases, leads to fewer blood transfusions, time spent in the ICU and in the hospital, and increases the utilization and efficiency of this technology.

MRI

	CON Approved Projected Utilization		CON Denied Projected Utilization		Difference Projected Utilization	
Unit of Service Exams	Number	Percent	Number	Percent	Number	Percent
Medicare	4,801	22.2%	4,373	23.6%	429	13.7%
RI Medicaid	**969**	**4.5%**	**902**	**4.9%**	**68**	**2.2%**
Non-RI Medicaid	251	1.2%	236	1.3%	16	0.5%
RIteCare	2,884	13.3%	2,411	13.0%	473	15.1%
Commercial / HMO / BC	9,692	44.7%	7,960	43.0%	1,732	55.3%
Self Pay	364	1.7%	306	1.6%	59	1.9%
Charity	1,281	5.9%	1,035	5.6%	247	7.9%
Other *	1,421	6.6%	1,310	7.1%	111	3.6%
Total	21,664	100.0%	18,531	100.0%	3,133	100.0%

* Other includes Champus, Workers' Compensation and Research

Two studies, "Magnetic resonance imaging and computer tomography in emergency assessment of patients with suspected acute stroke: a prospective comparison" and "A standardized MRI stroke protocol Comparison with CT in hyperacute intracerebral hemorrhage" show MRI as being a superior technology as compared to CT for purposes of diagnosing certain conditions. This superiority is especially noted in diagnosing stroke victims where quicker diagnosis leads to better medical outcomes and reduces hospital inpatient stays. The study involved typically suspected acute stroke victims coming to the emergency room. It was shown that approximately 25% of these patients had no detectable signs of damage upon arrival. The ability to diagnose the patient within 3 hours which is the approved timeframe for clot-busting therapy may completely avoid brain injury ultimately leading to decreased cost of stroke care (National Institute of Neurological Disorders and Stroke, a part of the National Institute of Health, Jun 26, 2007).

In another study, "A Standardized MRI Stroke Protocol", it was concluded that the use of a MRI exam alone saves time and money in diagnosing an acute stroke patient by eliminating the use of additional CT to rule out intracerebral hemorrahge. In a study conducted at Massachusetts General Hospital, a decline of 1.1 days for patients receiving a neurologic MRI the day before or on the day of admission was demonstrated. At an average cost of $2,129/day according to the study, the average savings of $2,342 (1.1 days) as compared to the cost of providing an MRI exam appears to be cost effective. Another study by Aetna for use in its Clinical Policy Bulletin, concludes that utilizing a CT to "clear the cervical spine" after blunt trauma can lead to missed injuries and supported adding an

MRI exam. It can be argued that missing such injuries can lead to increased complications, increased treatment costs and the cost of malpractice associated with a missed diagnosis.

Based on the above, not only is the cost of the incremental MRI's negligible, but providing them can ultimately lead to decreased costs in other areas, is efficient and cost effective, and results in better medical outcomes and quality of life for patients.

6. Appendix B #4 (c) and B #5 'Cost', please note that these questions are limited to patients not their families. Additionally, please revise your response to 'No' unless you can provide supporting financial information. Time is a more appropriate form of measure for availability. Cost is in reference to financial impact.

   The responses to Appendix B #4(c) has been revised to "No", and the response to Appendix B #5 has been revised to incorporate the part of the response titled "Cost" into the part of the response titled "Availability", as follows:

   Availability: Without the availability of the proposed MRI unit, ED patients will continue to have to be transported to the Radiology Department and wait for an open slot to receive an MRI exam, have a CT scan, or not be scanned at all. The result would be that these patients would have to wait longer to be scanned, diagnosed and have treatment prescribed, be exposed to the higher dosage of radiation from a CT scan, or have their for a diagnostic exam go unmet.

7. Appendix G #9, please note that the question as included does not match the question in the current version of the application. Please revise the question and do not provide the information as it is only applicable to new or out of state entities.

   Question #9 of Appendix G has been revised to match the current version of the CoN application, the response has been revised to say "Not Applicable", and copies of the Certificate of Incorporation, the Articles of Incorporation and the By Laws have been removed.

8. Appendix E, please note that a final selection of the equipment must be made. Please revise the responses to this Appendix to reflect a final selection.

   The response to Appendix E has been revised to reflect the Siemens MRI unit as the proposed equipment.

9. If there are any additional changes to the responses in the application as filed on 10 January 2012 and as resubmitted herein that were not identified as a deficiency by this letter, please identify these changes on a separate piece of paper and include the question number and the reason for the change.

   As a result of the change to the response in Appendix E, Q1 as discussed in the response to Deficiency #8 above, the response to Appendix E, Q3 has also been revised as follows:

   3. Please identify the reasons the alternative two options were rejected in favor of the proposed equipment.

   The proposed unit is being purchased in connection with other imaging equipment, and while all of the proposals are acceptable, the proposal from Siemens is more compatible with existing RIH imaging equipment.

Rhode Island Department of Health
Office of Health Systems Development
Three Capitol Hill, Room 404
Providence, RI 02908-5097

Phone: (401) 222-2788
Fax: (401) 222-1797

www.health.ri.gov/hsr/healthsystems/index.php

Certificate of Need Application Submission Instructions

Please submit 3 paper copies and an electronic copy [to: Valentina.Adamova@health.ri.gov] of the completed application to the Office of Health Systems Development, Rhode Island Department of Health, 3 Capitol Hill, Room 404, Providence, Rhode Island 02908. No application shall be accepted for review without a Letter of Intent submitted at least 45 days in advance.

Upon submission, the application will be reviewed for acceptability, and within ten (10) working days the applicant will be notified of any deficiencies if the application has been found not acceptable in form. Applications found substantially deficient may not be reviewed in the current cycle.

This application should be completed only after a thorough review of Chapter 15, Title 23, of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15 CON): http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/5342.pdf

Full responses to each question must be submitted and references to other responses shall not be accepted as a complete response. Attachments must be listed under an individual tab at the end of the application form. Applications should not include the instruction pages nor appendices not applicable to the proposal. The applications must be submitted in a soft bound format to facilitate the mailing of the application to the members of the Health Services Council. A table of contents must be included to identify the specific location of responses to questions.

Follow-up Questions: Additional questions will be sent to the applicant to supplement the information on the record specific to the proposal once the application is accepted for review.

Consultants, Legal and Application Fee Instructions

Consultants: The state agency may in effectuating the purposes of Chapter 23-15 of the Rhode Island General Laws, as amended, engage experts or consultants including, but not limited to, actuaries, investment bankers, accountants, attorneys, or industry analysts. Except for privileged or confidential communications between the state agency and engaged attorneys, all copies of final reports prepared by experts and consultants, and all costs and expenses associated with the reports, shall be public. All costs and expenses incurred under this provision shall be the responsibility of the applicant in an amount to be determined by the Director as he or she shall deem appropriate, the amount not to exceed $20,000. An application shall not be considered complete unless an

agreement has been executed with the Director for the payment of all costs and expenses, if determined by the state agency that such an agreement shall be required.

Legal: The state agency may engage legal services for the review of the application. All costs and expenses incurred shall be the responsibility of the applicant [pursuant to Chapter 23-1-53 of the Rhode Island General Laws]. An application shall not be considered complete unless an agreement has been executed with the Director for the payment of all legal services costs and expenses, if determined by the state agency that such an agreement shall be required.

Application: Pursuant to Chapters 23-15-10 and 23-15-11 of the Rhode Island General, the application fee requirements are as follows (health care facilities owned and operated by the State of Rhode Island are exempt):

- The application fee shall be paid by check and made payable to the Rhode Island General Treasurer,

- Application fees for applications accepted for review shall be non-refundable. Should your application be deemed unacceptable for review, the check for the application fee will be returned.

- The application fee formula is: base rate + (0.25%*capital cost)

Application Type	Base Rate
Regular Review*	$ 500
Accelerated Review*	$ 500
Expeditious Review*	$ 750
Tertiary or Specialty Care Review**	$ 10,000

*for non tertiary or specialty care review projects
**this rate applies to any application that checks off “5 H“

Certificate of Need Application Form
Version 03.2011

Name of Applicant	**Rhode Island Hospital**
Title of Application	**Emergency Department MRI**
Date of Submission	**January 10, 2012**
Type of review	__X__ Regular Review _____ Accelerated Review (complete Appendix A) _____ Expeditious Review (provide letter from the state agency)
Tax Status of Applicant	__X__ Non-Profit _____ For-Profit

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

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

Please have the appropriate individual attest to the following:
"I hereby certify that the information contained in this application is complete, accurate and true."

signed and dated by the President or Chief Executive Officer

Table of Contents:

PROJECT DESCRIPTION AND CONTACT INFORMATION

1. Please provide below an Executive Summary of the proposal

RIH proposes to acquire a 1.5T MRI magnet to meet the current and future demand for acute imaging of Emergency Department (ED) patients, at a capital cost of $3.2M, $1.75M for the equipment and $1.45M for space preparation.

The evolution of imaging from Dr Roentgen and the X-ray in 1898, to ultrasound and CT in the 1970's and MRI in 1990's has improved patient care and changed the manner of patient diagnosis. Imaging is integrated and critical to all aspects of medicine, and the access to imaging is key to timely diagnosis and treatment.

ED's have evolved from quiet corners of the hospital with part time staffing, to acute care facilities functioning like hospitals within a hospital, treating the sickest and most unstable patients. Annual ED visits nationally have increased by 10% in the last decade to over 125 million visits, and ED patients are sicker with more patients requiring admission than ever before. The Anderson Emergency Center (AEC), the adult ED at RIH, is a Level 1 Trauma Center responsible for the care of over 2 million people in Rhode Island and parts of Massachusetts and Connecticut. It also functions as a primary (soon to be comprehensive) stroke center accepting patient referrals from other primary stroke centers, with approximately 100,000 annual adult patient visits and ranking as one of the busiest ED's in the United States. More specifically, ED visits in Rhode Island decreased from 491,693 in FY'10 down to 483,842 in FY'11, a decrease of 7,851 visits. RIH ED visits, however, increased from 147,974 (96,969 adult and 51,005 pediatric) in FY'10 to 148,632 (99,294 adult and 49,338 pediatric) in FY'11, an increase of 658 visits (an increase of 2,325 adult and a decrease of 1,667 pediatric). Thus, the AEC should offer the people of Southern New England a standard of care that is comparable to what would be received in major regional centers elsewhere in the country, which requires an MRI unit to be sited within the ED.

MRI, unlike CT does not utilize ionizing radiation, but rather creates an image primarily based on the water content of tissue. Damaged and compromised tissue which has increased, or excess water (edema), forms the basis for imaging variation in MRI.

Within the Trauma care setting, stroke and spinal cord trauma and injury as well as infection is best diagnosed with MRI. Young women of childbearing age, with abdominal and pelvic pain are also best imaged with MRI avoiding radiation to genetically sensitive areas. MRI is also preferable to CT scan in children and young adults because it avoids radiation, which cumulatively over a lifetime can increase the risk of malignancy. Although CT does not provide the same level of imaging as MRI, it is oftentimes utilized in these clinical scenarios at RIH because of limited access to available MRI's and the need to transport patients outside the ED.

The RIH campus has only three MRI scanners. A 1.5T unit is sited in the pediatric imaging center to provide imaging to the pediatric population, and is a unique resource for the state, not available at other hospitals or freestanding MRI sites in RI, and requires the commitment of a pediatric sedation service to facilitate the care of these pediatric patients.

There are two scanners located within the Grosvenor Building. A 3.0T magnet is used for neuro imaging and is the only scanner in the state performing functional imaging of the brain, which is essential for pre-operative mapping of epilepsy and tumor resection patients. Spectroscopy, the chemical analysis of a focal area of brain, is also performed on this unit and is not available at any other sites in Rhode Island. Cerebral blood volume imaging is performed on this unit as well. All of these scans are very time consuming but essential for an expanding neuroscience program. This same unit also functions as one of our breast imaging MRI units. In addition there is 1.5T magnet in the Grosvenor Building used for cardiac imaging, a tedious imaging process necessary to support the cardiovascular surgery program. Again, this service is not available elsewhere in the state. This same unit also functions as our second breast imaging MRI unit.

These specialty functions coupled with the traditional existing demand for MRI has created an issue of capacity. The hours of operation for MRI have been expanded to the maximum to meet the increasing demands. Even with the expanded hours, these units are operating at above 85%. With the future volume projections, the capacity will exceed 90%. Maximum operating efficiency is obtained when the units function between 80% and 85%. By comparison other academic medical centers have a higher number of MRI units available for the volume of discharges and patient days.

MRI Units		Discharges	Patient Days
RIH	2 MRI main campus 1 Pediatric Imaging	35,140	190,123
Mass General Hospital	9 MRI on main campus 1 in the ED Additional units at Outpatient sites	50,000	289,276
BI	5 units on the main campus	41,382	200,398
Lahey	3 MRI on main campus 3 at off site locations	22,203	104,056
Brigham & Women's	6 MRI on main campus 2 off site locations	52,497	266,626
Boston Medical	3 MRI	28,907	126,723
Yale	8 MRI 1 in ED 1 in OR Some of these located off site locations	56,620 Approximate	286,172 Approximate

Optimal care requires situating an MRI within the ED. Presently, requests for an MRI scan from the ED on the existing magnets at RIH must be accommodated within the scheduling

constraints of inpatient and pediatric schedules with their own pressures for urgency. This situation often necessitates long waits in the ED until a spot on the schedule can be created. From a safety perspective, the acutely ill ED patient who is often unstable must travel long distances through the hospital campus to an available MRI unit. This significant transport time delays the definitive diagnosis that is provided by the MRI and crucial early treatment of the patient's problem. In addition, extra support personnel are drawn from the ED to accompany the patient from the Bridge building through the Davol and Main buildings, and finally to the Grosvenor building, a long and lonely trip at 2am! Taking nurses, techs and transporters away from the ED leaves the ED short on crucial personnel for the time that the MRI takes.

The slot on the MRI schedule now occupied by the ED patient displaces and delays scanning of inpatients and prolongs their length of stay. Similarly, many ED patients are admitted to an inpatient bed without having an MRI in the ED. This prolongs their wait for diagnosis until the MRI scan can be done, and adds to length of stay and medical costs.

In summary, the high-quality safe environment care that people want for their loved ones and themselves requires an MRI unit in the AEC. Patients will be scanned more promptly and safely and a diagnosis will be arrived at in a more expeditious manner, permitting earlier treatment and disposition.

2.

Capital Cost	**$3.2M**	From responses to Questions 10 and 11
Operating Cost	**$1.4M**	For the first full year after implementation, from response to Question 18
Date of Proposal Implementation	**January, 2013**	Month and year

3. Please provide the following information:

Information of the applicant:

Name:	**Rhode Island Hospital**	Telephone #:	**(401) 444-4000**
Address:	**593 Eddy Street, Providence, RI**	Zip Code:	**02903**

Information of the facility (if different from applicant): **Same**

Name:		Telephone #:	
Address:		Zip Code:	

Information of the Chief Executive Officer:

Name:	**Timothy J Babineau, MD**	Telephone #:	**(401) 444-5131**
Address:	**593 Eddy Street, Providence, RI**	Zip Code:	: **02903**
E-Mail:	**tbabineau@lifespan.org**	Fax #:	**(401) 444-4218**

Information for the person to contact regarding this proposal:

Name:	**Russell Gross**	Telephone #:	**(401) 444-7423**
Address:	**167 Point Street, Providence, RI**	Zip Code:	**02903**
E-Mail:	**rgross@lifespan.org**	Fax #:	**(401) 444-4857**

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

[**X**] Hospital [ ] Nursing facility [ ] Inpatient Hospice

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

[ ] Freestanding ambulatory surgical center [ ] Other (specify) _____

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

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

HEALTH PLANNING AND PUBLIC NEED

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

The applicant is not aware of any state health plans related to this proposal.

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

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

The applicant completed the table below working from the Department's last MRI study in the 2005/2006 time frame, calling each provider to verify the number of MRI units and making changes where necessary. While the applicant can attest that the information in the table below is accurate, it may not be complete as the applicant does not have access to information regarding any other MRI providers in the state. In addition, the applicant is not aware of any documented availability and accessibility problems in the state other that at its own sites, and was not able to obtain this information for other providers.

The applicant is aware, however, that because of the past proliferation in the community, MRI's have been classified as tertiary equipment in order to control the supply and unnecessary addition of MRI's. However the proposed RIH ED MRI addition is being driven by increasing demand and to enhance quality and safety for patients coming to the RIH ED who require an MRI. This increased demand emanates from the growing need among all classes of patients, including ED patients, for both specialized as well as standard MRI procedures due to the growing number of indications for MRI scans; the specialty nature of some MRI scans, many of which are only provided at RIH within the state; and in order to minimize if not eliminate the substitution of MRI with CT which has higher levels of radiation dosage than MRI, due to the lack of available capacity to handle the demand, especially in the ED. The overall impact of these factors at RIH is very high use and increased machine time of the three existing MRI units; longer waiting time for an MRI; increased inpatients days over time; and delays in diagnoses and development of treatment plans for patients requiring an MRI, especially for ED patients.

Name of Facility/Service Provider	List similar type of Service/ Equipment*	Documented Availability Problems (Y/N)	Documented Accessibility Problems (Y/N)	Distance from Applicant (in miles)
Kent	1	?	?	10
Landmark	1	?	?	16
Memorial	1	?	?	6
Miriam	1	N	N	4
Newport	1	N	N	37
Rhode Island	3	N	N	0
Roger Williams	1	?	?	3
South County	1	?	?	30
St Joseph	1	?	?	7
Westerly	1	?	?	46
Women and Infants	1	?	?	0
Bristol County Open MRI Services, Inc	1	?	?	17
Nate Whipple Radiology, Lincoln	1	?	?	16
Open MRI of New England, N Smithfield	1	?	?	17
Open MRI of New England, Warwick	2	?	?	9
Open MRI of New England, Cumberland	2	?	?	15
Open MRI of New England, Providence	1	?	?	3
Open MRI of New England, E Providence	1	?	?	3
Open MRI of New England, Westerly	2	?	?	44
Rhode Island Medical Imaging, Providence	2	?	?	3
Rhode Island Medical Imaging, E Providence	1	?	?	3
Rhode Island Medical Imaging, E Greenwich	1	?	?	15
Rhode Island Medical Imaging, Pawtucket	1	?	?	6
Rhode Island Medical Imaging, Lincoln	1	?	?	9
The Imaging Center, Cranston	2	?	?	4
The MRI Center, Johnston	1	?	?	7
Toll Gate Radiology, Inc, Warwick	1	?	?	12
XRA Medical Imaging, Cranston	1	?	?	4
XRA Medical Imaging, Johnston	1	?	?	7
XRA Medical Imaging, Middletown	1	?	?	26
XRA Medical Imaging, Wakefield	1	?	?	33
XRA Medical Imaging, Warwick	1	?	?	12
Newport Hospital Portsmouth Imaging Ctr.	1	N	N	32

***All MRI's**

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

The proposed equipment, if implemented, will not result in any unnecessary duplication of similar existing services or equipment due to the unique use of the existing MRI units at RIH as described below, and because the proposed equipment will be utilized primarily for patients coming to the only Level 1 Trauma Center in the state who require an MRI

The RIH campus has only three MRI scanners. A 1.5T unit is sited in the pediatric imaging center to provide imaging to the pediatric population, many of whom cannot hold still or understand what is happening and require sedation in order to lie quietly within the scanner and permit imaging without movement, resulting in a very time consuming process. This pediatric scanner is a unique resource for the state not available at other hospitals or freestanding MRI sites in RI, and requires the commitment of a pediatric sedation service to facilitate the care of these pediatric patients.

There are two scanners located within the Grosvenor Building. The 3.0T magnet is used for neuro imaging and is the only scanner in the state performing functional imaging of the brain which is essential for pre-operative mapping of epilepsy and tumor resection patients. Spectroscopy, the chemical analysis of a focal area of brain, is also performed on this unit and is not available at any other sites in Rhode Island. Cerebral blood volume imaging is performed on this unit as well. All of these scans are very time consuming but essential for an expanding neuroscience program. This same unit also functions as one of our breast imaging MRI units. In addition there is 1.5T magnet in the Grosvenor Building used for cardiac imaging, a tedious imaging process necessary to support the cardiovascular surgery program. Again, a service not available elsewhere in the state. This same unit also functions as our second breast imaging MRI unit.

The niche focus of our scanners requires sophisticated and prolonged scanning protocols, which are in conflict with expeditious delivery of imaging services to ED patients. The focus of these scanners is quite different from that of free standing outpatient MRIs that service ambulatory patients requiring routine scanning protocols. Hence, the proposed ED magnet will have a completely different mission from that of our present scanner alignment as well as other magnets throughout the state, and will be charged to safely and expeditiously provide a diagnosis to patients in the AEC.

In addition, since the proposed ED MRI unit will operate 24 hours a day, it will make the overall operation of the Radiology Department more efficient by enabling the existing Radiology Department MRI unit currently operating 24 hours a day to be shut down at night, with any inpatients requiring an MRI during that time scanned on the ED MRI unit, as well as serve as back-up during the day to accommodate inpatients when available and when there are no open slots on any of the existing Radiology Department MRI units.

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

All of Rhode Island and the following MA Towns: Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Douglas, Fall River, Franklin, Millville, New Bedford, N. Attleboro, Plainville, Rehoboth, Seekonk, Somerset, Swansea, Uxbridge, Westport & Wrentham. Based on Census data, the population of Rhode Island is 1,052,567, with the population of the MA towns projected to be approximately 433,389, for a total projected population of 1,485,956.

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

Access to MRI imaging in the RIH ED and reduction in the radiation exposure when CT is used as an alternative to MRI, is needed by the population served by the hospital in order to reduce waiting time in the ED and to improve overall quality of care.

Current wait time in the ED for an MRI has been measured at 2 hours and 20 minutes on average, with some cases much longer. It is difficult to measure the wait time for all cases, as some patients are processed to inpatient or observation status before the MRI is performed. As a result, some ED patients are not scanned until they are admitted to an inpatient or observation unit, delaying diagnosis and treatment. The snowball effect of having to transport ED patients to the Radiology Department for an MRI leads to delays in MRI's for inpatients. While 90% of all Inpatient MRI's are done within 24 hours, 10% exceed 24 hours with 24% between 12 and 24 hours. These delays are caused in large part due to the need to "fit-in" ED patients who need an MRI, delaying the scanning of inpatients.

In addition, although CT does not provide the same level of imaging and exposes patients to higher levels of radiation than MRI, it is oftentimes utilized in lieu of MRI due to the limited access to available MRI's and the need to transport patients outside the ED.

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

The first set of tables below is for all patients who come to RIH and have an MRI scan, with the second set of tables below being for just those patients who come to the RIH ED and have an MRI scan.

RIH MRI Imaging (All Patients)

Actual (last 4 years)	FY **2009**	FY **2010**	FY **2011**	FY **2012**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**15,670**	**16,597**	**17,690**	**18,531**
Throughput Possible (#) Exams	**21,424**	**22,291**	**23,157**	**23,157**
Utilization Rate (%) Exams	**73.1%**	**74.5%**	**76.4**	**80.0%**
Operational Utilization Rate (%) Exams*	**83.0%**	**77.0%**	**85.0%**	**87%**
Utilization (#) Days**	**182,410**	**188,535**	**190,123**	**195,906**
Throughput Possible (#) Days	**234,330**	**240,170**	**245,280**	**245,952**
Utilization Rate (%) Days	**77.8%**	**78.5%**	**77.5%**	**79.7%**

Projected	FY **2013**	FY **2014**	FY **2015**	FY **2016**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**20,040**	**21,664**	**22,175**	**22,705**
Throughput Possible (#) Exams	**28,981**	**30,923**	**30,923**	**30,923**
Utilization Rate (%) Exams	**69.1%**	**70.1%**	**71.7%**	**73.4%**
Operational Utilization Rate (%) Exams*	**78%**	**78%**	**79%**	**81%**
Utilization (#) Days**	**194,315**	**192,740**	**191,180**	**189,637**
Throughput Possible (#) Days	**245,280**	**250,390**	**250,390**	**251,076**
Utilization Rate (%) Days	**79.2%**	**77.0%**	**76.4%**	**75.5%**

***Operational utilization is a calculation of the utilization of the MRI units during the peak hours of 7am to 9pm, which takes into consideration both specialty exams which require longer periods of time, such as functional MRI or pediatric MRI requiring sedation, and block times required to coordinate MRI with other procedures such as cyber knife.**

****Excludes Observation Bed Days**

RIH MRI Imaging (ED Patients Only)

Actual (last 3 years)	FY **2009**	FY **2010**	FY **2011**	FY **2012**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**953**	**1,200**	**1,415**	**1,900**
Throughput Possible (#) Exams	**21,424**	**22,291**	**23,157**	**23,157**
Utilization Rate (%) Exams	**4.4%**	**5.4%**	**6.1%**	**8.2%**
Operational Utilization Rate (%) Exams*	**N/A**	**N/A**	**N/A**	**N/A**
Utilization (#) Days**	**N/A**	**N/A**	**N/A**	**N/A**
Throughput Possible (#) Days	**N/A**	**N/A**	**N/A**	**N/A**
Utilization Rate (%) Days	**N/A**	**N/A**	**N/A**	**N/A**

Projected	FY **2013**	FY **2014**	FY **2015**	FY **2016**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**2,870**	**4,209**	**4,416**	**4,633**
Throughput Possible (#) Exams	**28,981**	**30,923**	**30,923**	**30,923**
Utilization Rate (%) Exams	**9.9%**	**13.6%**	**14.3%**	**15.0%**
Operational Utilization Rate (%) Exams*	**N/A**	**N/A**	**N/A**	**N/A**
Utilization (#) Days**	**N/A**	**N/A**	**N/A**	**N/A**
Throughput Possible (#) Days	**N/A**	**N/A**	**N/A**	**N/A**
Utilization Rate (%) Days	**N/A**	**N/A**	**N/A**	**N/A**

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

None of the need for the services proposed as described in the response to D. above are currently being satisfied, but all of the need would be satisfied with the approval and implementation of this proposal.

Indications for MRI expand regularly and concerns about radiation dangers become more pervasive. Our Emergency Medicine physicians and nursing staff are keenly aware of the difficulty in obtaining prompt MRI access from the ED. A major consequence is utilization of CT, or to delay the MRI until the patent is admitted to an inpatient nursing unit.

On average, four patients/day, or approximately 1 percent of the average of 290 daily ED visits, are sent to the existing MRI units from the ED. We anticipate this will double with an MRI available in the ED. Utilization for abdominal imaging will increase and more stroke imaging will be done with MRI, providing the opportunity to minimize radiation exposure that occurs with CT. Situating the MRI in the ED will provide for greater geographic

proximity, more timely diagnosis, and the opportunity to keep patients under observation and maintain them in the safe, monitored environment provided by the ED.

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

While there are other providers of MRI imaging in the state, the pubic need described in response to parts D and F of this question is unique to and self-contained within the RIH ED due to the volume of annual visits, the niche focus of the hospital's MRI units described in the response to part B of this question, and because the RIH ED is the only Level 1 Trauma Center in the state. Thus, alternative proposals involving a collaborative approach with existing providers of similar services are not viable. The four alternatives that were considered are as follows:

Alternative 1: Do nothing, and continue to transport ED patients requiring an MRI to the Radiology Department.

Alternative 2: Continue to use CT as an alternative to MRI.

Alternative 3: Acquire and install an MRI unit in the ED.

Alternative 4: Acquire and install an MRI unit in a location adjacent to the ED.

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

Alternative 1 - Do nothing, and continue to transport ED patients requiring an MRI to the Radiology Department: The existing units in the Grosvenor building are about 1,200 feet away, and would continue to involve the transport of the patient through various corridors that have public traffic. Due to the distance and utilization of the existing units, the hospital does not see this option as a viable solution. In addition, this alternative would have the impact of decreasing the available capacity for one of the existing specialized MRI units as discussed in the response to Part 7B above.

Alternative 2 - Continue to use CT as an alternative to MRI: ED patients would continue to be exposed to higher levels of radiation than would be necessary in those cases where a CT scan was used rather than waiting for a slot on one of the existing MRI units. . In addition, this alternative would also have the impact of decreasing the available capacity for one of the existing specialized MRI units as discussed in the response to Part 7B above.

Alternative 3 - Acquire and install an MRI unit in the ED: This is the most efficient alternative to meet the MRI needs of ED patients, and provides continuity of care in a consistent environment without the patient having to travel lengthy distances to other parts of the hospital. This alternative will also enhance safety by reducing the number of ED patients given a CT scan with a higher level of radiation in lieu of waiting for an MRI, and will free up slots on the existing MRI units for inpatients and outpatients.

<u>Alternative 4 - Acquire and install an MRI unit in a location adjacent to the ED</u>: This alternative would still involve the transportation of patients to other areas of the hospital. The two closest locations are the MOC and Davol buildings, neither of which was designed to accommodate an MRI and pose construction (structural) challenges. Patients would still have to be transported which would not be beneficial for their care, and the reduction in the use of CT as an alternative to MRI would not be as significant as it would be with alternative 3.

HEALTH DISPARITIES AND CHARITY CARE

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

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

   The applicant identified health disparities in its service areas from the May 2004 report "A Healthier Rhode Island by 2010: A Plan for Action" The report identifies groups with the greatest health disparities for each "Leading Health Indicators" (LHI's), noting that overall, there are 5 groups that most frequently appear to have significant health disparities across several LHI's:

   • Adult males;
   • Rhode Islanders with lower levels of education (high school education or less);
   • Rhode Islanders with lower levels of income (less than $35,000);
   • Blacks of all ages; and
   • Adolescents in the 12th grade.

   In addition, the report identified the following groups as having the greatest health disparities within each LHI:

   PHYSICAL ACTIVITY
   Adults
   Lower levels of education (less than high school; high school grad/GED)
   Over age 25
   With disabilities
   Hispanic adults
   Black adults
   Lower levels of income (less than $25,000; $25,000-34,999; don't know/refused)

   Adolescents
   Adolescent females
   Adolescents in 12th grade
   Hispanic adolescents

OVERWEIGHT AND OBESITY
Adults
Black adults
Less than a high school education
With disabilities
Ages 4
Adolescents
Black adolescents
Children and adolescents with household incomes below the federal poverty level
Hispanic adolescents
Fruits and Vegetables
Black adults
With less than a high school education
Adult males

TOBACCO USE
Adults
Ages 18-44
Lower incomes (less than $25,000; $25,000-34,999; $35,000-49,999)
Lower levels of education (less than high school); high school grad/GED; at least some college)
Living in urban areas
Adolescents
Adolescents in 12th grade
White adolescents

SUBSTANCE ABUSE
Adolescents: Alcohol or Illicit Drugs
Adolescents in 12th grade
Adolescents: Marijuana
White adolescents
Binge Drinking
Ages 18-24
Adult males
More than a high school education (high school grad/GED; at least some college; college grad or more)

RESPONSIBLE SEXUAL BEHAVIOR
Adolescents
Adolescents in 12th grade
Unmarried Sexually Active Males
Unmarried, sexually active males ages
Unmarried, sexually active males with incomes less than $25,000
White unmarried, sexually active males
Unmarried Sexually Active Females
Unmarried, sexually active females ages 35-44

MENTAL HEALTH
Suicide
Males 16/100,000

INJURY AND VIOLENCE
Homicide
Blacks of all ages 16/100,000
Males 4/100,000
Motor Vehicle Crashes
Blacks of all ages 15/100,000
Males 13/100,000
Rhode Islanders aged 15 to 24 and 85+ 16/100,000

ENVIRONMENTAL QUALITY
Lead Poisoning
Black children

IMMUNIZATION
Flu Vaccine
Living in urban areas
Less than high school degree
Ages 65-74
Pneumococcal Vaccine
Ages 65-74
Without disabilities

ACCESS TO HEALTH CARE
Health Insurance Coverage
Incomes of less than $25,000
Ages 18-24
Black adults
Less than a high school degree
On-going Source of Care
Ages 18-24
Adult males
Incomes of $25,000 to $34,999
Adequate Prenatal Care
Black women
Asian/Pacific Islander women
American Indian/Alaskan Native women Hispanic women

In a follow-up plan in May 2006 "A Healthy People 2010: A Mid-Course Review", disparities are identified by racial ethnic groups Hispanic/Latino:
1. Physical activity
2. Overweight and Obesity
3. Fruit & Vegetable Consumption

4. Homicides
5. Access to Health Insurance
6. Prenatal Care
African American/Black (Non-Hispanic):
1. Physical activity
2. Overweight and Obesity
3. Fruit & Vegetable Consumption
4. Tobacco Use
5. Homicides
6. Access to Health Insurance
7. Prenatal Care
Asian & Pacific Islander:
1. Access to Health Insurance
2. Prenatal Care
Native American and American Indian:
1. Tobacco Use
2. Access to Prenatal Care

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

While this project will not directly contribute to reducing or eliminating any of the health disparities in the applicant's service area identified in A. above, it does support Access to Health Care, one of the leading indicators of health disparities in Rhode Island, by ensuring state-of-the-art MRI scanning equipment is in place in the ED in order to enhance the safety and quality of ED patients; and by providing additional MRI capacity to meet the demand for all classes of patients requiring an MRI.

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

See Attachment 1, Financial Assistance Policy

FINANCIAL ANALYSIS

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

CAPITAL EXPENDITURES		
	Amount	**Percent of Total**
Survey/Studies	$5	0.2%
Fees/Permits	$14	0.5%
Architect	$73	2.3%
"Soft" Construction Costs	**$92**	**2.9%**
Site Preparation	$0	0%
Demolition	$0	0%
Renovation	$1,358	42.3%
New Construction	$0	0%
Contingency	$0	0%
"Hard" Construction Costs	**$1,358**	**42.3%**
Furnishings	$0	0%
Movable Equipment	$0	0%
Fixed Equipment	$1,750	54.5%
"Equipment" Costs	**$1,750**	**54.5%**
Capitalized Interest	$0	0%
Bond Costs/Insurance	$0	0%
Debt Services Reserve[1]	$0	0%
Accounting/Legal	$0	0%
Financing Fees	$0	0%
"Financing" Costs	**$0**	**0%**
Land	$0	0%
Other (specify CoN Fee)	$18	0.3%
"Other" Costs	**$18**	**0.3%**
TOTAL CAPITAL COSTS	**$3,218**	**100%**

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

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

No contingency was included in the capital cost for this project.

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

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

Funding for capital costs will come from current unrestricted cash reserves and future unrestricted income from operations. Incremental operating expenses will be funded by income earned on incremental volume.

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

	Project (000)	Facility (000)	Percent
Capital	**$3,218**	**$1,187,383**	**0.27%**
Operating Expense	**$1,433**	**$1,065,552**	**0.13%**

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

No price escalation is estimated, given the immediate timeframe and nature of the proposal.

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

Source	Amount	Percent	Interest Rate	Terms (Yrs.)	List source(s) of funds (and amount if multiple sources)
Equity*	**$3,218,000**	**100**%			**Donations, unrestricted cash reserves, and future unrestricted income from operating income**
Debt**	$**0**	**0**%	**0**%		
Lease**	$**0**	**0**%	**0**%		
TOTAL	**$3,218,000**	**100%**			

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

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

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

13. Has a feasibility study been conducted of fundraising potential? Yes___ N **_X_**

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

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

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

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

Depreciation/Amortization Schedule - Straight Line Method					
		Equipment			
	Improvements	**Fixed**	**Movable**	**Amortization**	**Total**
Total Cost	$1,450,000	$1,750,000	$0	$18,000	$ 3,218,000
(-) Salvage Value	$0	$0	$0	$0	$0
(=) Amount Expensed	$0	$0	$0	$0	$0
(/) Average Life (Yrs.)	25	5		14	8
(=) Annual Depreciation	**$58,000**	**$350,000**	**$**	**$1,000**	**$409,000**

1 Must equal the total capital cost (Question 10 above) less the cost of land and less the cost of any assets to be acquired through lease financing

2 Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 18 (below).

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

	Existing		**Additions/(Reductions)**		**New Totals**	
Personnel	**# of FTEs**	**Payroll W/Fringes (000)**	**# of FTEs**	**Payroll W/Fringes (000)**	**# of FTEs**	**Payroll W/Fringes (000)**
Management	179.6	$28,048	0.0	$0.0	179.6	$28,048
Professional / Tech	1,074.8	110,921	4.5	547	1,079.3	111,468
Nursing	1,774.6	198,678	0.0	0.0	1,774.7	198,678
Service / Maintenance	915.8	51,766	0.0	0.0	915.8	51,766
Office / Clerical	1,238.4	76,874	0.0	0.0	1,238.4	76,874
Physician / Resident	682.7	129,607	0.0	0.0	682.7	129,607
TOTAL	**5,865.9**	**$595,894**	**4.5**	**$547**	**5,870.4**	**$596,441**

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

INSTRUCTIONS:

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

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

Recruitment of MRI Technologists will comply with RIH Human Resources policies and applicable Union contract provisions. The MRI technologist position is posted internally first, and after a one week period would be posted externally. After being hired, MRI Technologists go through both the Lifespan New Employee Department Orientation and the MRI Technologist training program, followed by the MRI Competency test to assess new employee's training progress across all MRI exams using the MRI Competency Evaluation Worksheet to track individual exam competency. In addition, the MRI Technologist Annual Competency test is completed each year as part of the evaluation process.

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

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY (000)					
	Actual Previous Year 2011 (1)	**Budgeted Current Year 2012 (2)**	**<-- FIRST FULL OPERATING YEAR 2014 -->**		
			CON Denied (3)	**CON Approved (4)**	**Incremental Difference *1* (5)**
REVENUES:					
Net Patient Revenue	$915,068	$949,304	$1,009,329	$1,011,910	$2,581
Other:	43,283	39,947	35,371	35,371	
Total Revenue	**958,351**	**989,251**	**1,044,700**	**1,047,281**	**2,581**
EXPENSES:					
Payroll w/Fringes	555,546	562,454	595,894	596,441	547
Supplies	148,341	149,617	161,931	162,015	84
Other Controllable Exp	146,765	167,730	184,973	185,123	150
Total Controllable Exp	**850,652**	**879,801**	**942,798**	**943,580**	**742**
Bad Debt	62,147	64,368	70,802	70,980	178
Interest Expense	14,188	13,811	12,916	12,916	
Depreciation/Amortization	34,682	36,582	37,603	38,012	409
Total Other Expenses	111,017	114,761	121,321	121,908	587

Total Expenses	**961,669**	**994,562**	**1,064,119**	**1,065,448**	**1,329**
Income (Loss) from Operations	**(3,318)**	**(5,311)**	**(19,419)**	**(17,709)**	**1,710**
Other Income (Expenses)					
Investment Income	6,224	7,081	6,670	6,670	
Other Gains (Losses)	(8,307)				
Total Other Income	(2,083)	7,081	6,670	6,670	
Net Income (Loss)	**$(5,401)**	**$1,770**	**$(12,749)**	**$(11,497)**	**$1,252**

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

Service Type: Discharges					
Service (#s):	35,140	36,060	36,060	36,060	0
Net Revenue Per Unit *8*	$26,041	$26,326	$27,990	$28,062	$72
Expense Per Unit	$26,963	$27,198	$29,151	$29,188	$37

Service Type: Exams					
Service (#s):	17,690	18,531	18,531	21,664	3,133
Net Revenue Per Unit *8*				$119	$119
Expense Per Unit	$196	$183	$193	$ 226	$33

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

1 The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column –3-.

2 Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.

3 Payroll with fringe benefits (column -5-) equals that identified in Question 16 above.

4 Bad Debt is the same as that identified in column -4-.

5 Interest Expense equals the first full year's interest paid on debt.

6 Depreciation equals a full year's depreciation (Question 15 above), not the half year booked in the year of purchase.

7 Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;

8 Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

19. Please provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on

individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

Projected First Full Operating Year: FY 2014									
	Implemented			Not Implemented			Difference		
Payor Mix	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue	Projected Utilization		Total Revenue
	#	%	$	#	%	$	#	%	$
Medicare	10,122	28.1%	$ 224,914	10,122	28.1%	$ 224,790			$124
RI Medicaid	1,736	4.8%	41,631	1,736	4.8%	41,612			18
Non-RI Medicaid	519	1.4%	12,433	519	1.4%	12,430			4
RIteCare	4,946	13.7%	110,590	4,946	13.7%	110,204			386
Com/HMO/ BC	15,577	43.2%	531,411	15,577	43.2%	529,482			1,929
Self Pay	543	1.5%	38,061	543	1.5%	38,002			59
Charity Care	1,837	5.1%	0	1,837	5.1%	0			
Other*	780	2.2%	52,868	780	2.2%	52,809			59
TOTAL	**36,060**	**100.0%**	**$1,011,910**	**36,060**	**100.0%**	**$1,009,329**			**$ 2,581**

*** Other includes Champus, Workers Compensation and Research**

20.) Please provide the following:

A. Please provide audited financial statements for the most recent year available.
See Attachment 2, Audited Financial Statements

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

As discussed elsewhere in this application, approval of this proposal will provide continuity of care for ED patients in need of an MRI exam in a consistent environment without the patient having to travel lengthy distances to other parts of the hospital. In addition, patients will be scanned more promptly and safely, a diagnosis will be arrived at in a more expeditious manner permitting earlier treatment and disposition, waiting time for ED patients requiring an MRI exam be reduced, safety will be enhanced by reducing the number of ED patients given a CT scan with a higher level of radiation in lieu of waiting for an MRI, and slots will be freed up on the existing MRI units for inpatients and outpatients. Without approval of this proposal the environment of care that the residents of Rhode Island and all people coming to the AEC who require an MRI exam expect and deserve will not be realized, and the

quality, safety and continuity of care for ED patients in need of an MRI exam will not be enhanced.

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

There are no derivable operating efficiencies resulting in lower total or unit costs as a result of this proposal.

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

The renovations and construction involved in this proposal will not affect the existing HVAC system, utilities or architectural layout, nor affect the ongoing operation of the ED. However the project will require the loss of one of the existing Radiology rooms.

23.) Please comment on the affordability of the proposal, specifically addressing the relative ability of the people of the state to pay for or incur the cost of the proposal, at the time, place and under the circumstances proposed. Additionally, please include in your discussion the consideration of the state's economy.

This proposal is adding incremental annual operating expense of $1.4M, but is being funded with 100% equity. Therefore, and in consideration of the current condition of the state's troubled economy, the impact on the economy or ability of the people of the state to pay for or incur the cost of this proposal has been minimized to the extent possible.

The projected net revenue of approximately $2.5 million represents a negligible (less than 1/10 of 1%) change in healthcare cost spending across the 10 acute care hospitals in the state of Rhode Island (based on 2010 figures, HARI).

Relative to the state's publicly funded portion of healthcare costs, the Medicaid net revenue of $18,000 (See response to Question #19) associated with providing an additional 68 MRI exams to Medicaid patients (See table below) represents less than 1/1000 of 1% of Medicaid's total medical expense spending (based on SFY 2010 Rhode Island Annual Medicaid Expenditure Report, Executive Office of Health and Human Services June 2011).

It should be noted that this incremental impact is associated with providing 1,133 net incremental MRI exams, and replacement of 2,000 existing CT scans projected to be replaced by MRI exams. It is believed that these exams and associated cost will ultimately be provided, whether at RIH or some other facility and potentially with the same delays currently experienced by people coming to the RIH ED who require an MRI exam, independent of locating an MRI unit in RIH ED.

In attempting to answer the question of whether or not this increased cost is "worth it", an article titled, "How Changes in Medical Technology Affect Health Care Costs" suggests that it is not possible to measure the direct effect of spending associated with advancing technology. There are simply too many variables and they interrelate in such a way that makes it impractical

to determine the cost. Another article titled "Improving Patient Care Through Early Health", says the use of advanced radiology technology allows for complete diagnosis of trauma victims within 3 hours of arrival, avoids unnecessary surgery in many cases, leads to fewer blood transfusions, time spent in the ICU and in the hospital, and increases the utilization and efficiency of this technology.

MRI

	CON Approved Projected Utilization		CON Denied Projected Utilization		Difference Projected Utilization	
Unit of Service Exams	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Medicare	4,801	22.2%	4,373	23.6%	429	13.7%
RI Medicaid	**969**	**4.5%**	**902**	**4.9%**	**68**	**2.2%**
Non-RI Medicaid	251	1.2%	236	1.3%	16	0.5%
RIteCare	2,884	13.3%	2,411	13.0%	473	15.1%
Commercial / HMO / BC	9,692	44.7%	7,960	43.0%	1,732	55.3%
Self Pay	364	1.7%	306	1.6%	59	1.9%
Charity	1,281	5.9%	1,035	5.6%	247	7.9%
Other *	1,421	6.6%	1,310	7.1%	111	3.6%
Total	21,664	100.0%	18,531	100.0%	3,133	100.0%

* Other includes Champus, Workers' Compensation and Research

Two studies, "Magnetic resonance imaging and computer tomography in emergency assessment of patients with suspected acute stroke: a prospective comparison" and "A standardized MRI stroke protocol Comparison with CT in hyperacute intracerebral hemorrhage" show MRI as being a superior technology as compared to CT for purposes of diagnosing certain conditions. This superiority is especially noted in diagnosing stroke victims where quicker diagnosis leads to better medical outcomes and reduces hospital inpatient stays. The study involved typically suspected acute stroke victims coming to the emergency room. It was shown that approximately 25% of these patients had no detectable signs of damage upon arrival. The ability to diagnose the patient within 3 hours which is the approved timeframe for clot-busting therapy may completely avoid brain injury ultimately leading to decreased cost of stroke care (National Institute of Neurological Disorders and Stroke, a part of the National Institute of Health, Jun 26, 2007).

In another study, "A Standardized MRI Stroke Protocol", it was concluded that the use of a MRI exam alone saves time and money in diagnosing an acute stroke patient by eliminating the use of additional CT to rule out intracerebral hemorrahge. In a study conducted at Massachusetts General Hospital, a decline of 1.1 days for patients receiving a neurologic MRI the day before or on the day of admission was demonstrated. At an average cost of $2,129/day according to the study, the average savings of $2,342 (1.1 days) as compared to the cost of

providing an MRI exam appears to be cost effective. Another study by Aetna for use in its Clinical Policy Bulletin, concludes that utilizing a CT to "clear the cervical spine" after blunt trauma can lead to missed injuries and supported adding an MRI exam. It can be argued that missing such injuries can lead to increased complications, increased treatment costs and the cost of malpractice associated with a missed diagnosis.

Based on the above, not only is the cost of the incremental MRI's negligible, but providing them can ultimately lead to decreased costs in other areas, is efficient and cost effective, and results in better medical outcomes and quality of life for patients.

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

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

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

RIH does not have any outstanding cited deficiencies.

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

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

C) If this proposal involves construction or renovation:

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

The existing areas that will be impacted by the proposed MRI unit are a supply room and a radiology room, none of which will interrupt service.

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

This proposal will enhance the access, availability, safety and quality of MRI imaging capability for people in the community served by RIH who come to the AEC and require MRI imaging, including people of the neighborhoods close to the hospital, by providing the ability for MRI imaging in the ED, thereby eliminating the need to transport patients to the Radiology Department and the time associated with such transport, waiting for an MRI slot to open up in the Radiology Department, and reducing exposure to higher levels of radiation by minimizing

the use of CT in lieu of MRI. In addition as previously noted, all patients utilizing the AEC will have access to MRI in the ED if required, which they do not have at the present time. Since the proposed MRI unit is not an elective outpatient scanner it will not duplicate or impact any free standing MRIs in the community.

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

There is no impact on service linkages with other health care facilities or providers, nor on achieving continuity of patient care from this proposal.

27.) Please address the following:

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

As an Academic Medical Center RIH already has significant infrastructure in place that enhances communication between specialists in the hospital and primary caregivers in the community. As it relates to diagnostic imaging, RIH and Lifespan have been making efforts to improve the flow of communication and information to assist in the care of patients. All physicians on the staff can access "LifeLinks", the Hospital's EMR, and can order exams and review all exam results from any location for images performed in any Lifespan site. In addition, Lifespan is working with physician offices with EMR in place to electronically provide the results of imaging exams directly into their records. All images from all Lifespan sites are now integrated in the PACS (picture archiving computer system) so physicians/radiologists reading the images can see images across all hospitals for comparison and establishing appropriate protocoling of exams.

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

There are no preventive services delivered in a primary care setting that could prevent overuse of the proposed medical equipment.

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

There are no specific investments planned in parallel with this proposal. However, RIH and Lifespan have made and will continue to make investments to expand supportive primary and ambulatory care services to the communities in its service area, such as, the relocation of the Hallet Diabetes Center to 900 Warren in East Providence, enhancing community access to residents in need of diabetes care; establishment of an Outpatient Dialysis center on Baker Street in Providence, enhancing community access to residents in need of dialysis treatment; and expansion of ambulatory surgery to the community with the acquisition of the Wayland Square SurgiCenter.

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

The placement of supportive primary care and ambulatory care services in the community in and around RIH, such as those described in the response to Part C above, will increase capacity for these services, which in turn should help to reduce inappropriate ED use.

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

See Attachment 3 for map and tables of Health Professional shortages in RI. According to map, tables and information at the web site noted above, RIH is located in an area designated as a primary care, dental and mental health, Health Professional Shortage Area (HPSA).

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

This proposal supports the health care system of the state by enhancing the safety and quality of MRI imaging for patients coming to the only Level 1 Trauma Center in the state who require an MRI scan through the citing of an MRI unit in the AEC, thereby reducing the waiting time for an MRI for these patients, eliminating the need for transport to the Radiology Department, minimizing the use of CT with a higher level of radiation exposure in lieu of waiting for an MRI, expediting the diagnosis and treatment of these patients, and maintaining the continuity of the high-quality safe environment care that these patients require and deserve.

Select and complete the Appendixes applicable to this application:

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

Appendix B

Provision of Health Services to Inpatients

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

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

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

Efficiency: This proposal is the most superior in terms of improving the overall efficiency of the Radiology Department by eliminating the need for ED patients to be transported to the Radiology Department for MRI exams; minimizing the use of CT with a higher dosage of radiation for ED patients in lieu of waiting for an open slot on one of the existing MRI units to receive an MRI exam, and thereby delaying diagnosis and treatment; and freeing up capacity on existing MRI units for inpatients and outpatients.

Appropriateness: As stated throughout this application and above under "Efficiency", this proposal is the most superior in terms enhancing the safety, efficiency and quality of patient care; and brings the RIH ED up to the standard of care for a Level 1 Trauma Center .

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

Cost: While doing nothing and continuing to either transport ED patients to the Radiology Department or prescribing CT in lieu of waiting for a slot to open on one of the existing MRI units would both be superior in terms of cost, both are inferior in terms of efficiency and appropriateness to the instant proposal as discussed below.

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

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

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

Availability: Without the availability of the proposed MRI unit, ED patients will continue to have to be transported to the Radiology Department and wait for an open slot to receive an

MRI exam, have a CT scan, or not be scanned at all. The result would be that these patients would have to wait longer to be scanned, diagnosed and have treatment prescribed, be exposed to the higher dosage of radiation from a CT scan, or have their for a diagnostic exam go unmet.

Access: Without access to the proposed MRI unit the impact will be the same as noted under availability above, ED patients will continue to have to be transported to the Radiology Department and wait for an open slot to receive an MRI exams, have a CT scan with a higher dosage of radiation performed, or not be scanned at all. In addition, inpatients and outpatients would continue to experience delays in having MRI exams, due to the need to continue to schedule ED patients on the three existing MRI units.

Appendix D

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

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

RIH proposes to acquire and install a new 1.5T MRI magnet and associated control, equipment and prep rooms in 1,495 sq. ft. of space in the AEC, currently used for storage, a radiology room and a radiology holding bay. Schematic drawings are attached.

2. Please provide a letter stating that a preliminary review by a Licensed architect indicates that the proposal is in full compliance with the 2006 edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" and identify the sections of the guidelines used for review. Please include the name of the consulting architect, and their RI Registration (license) number and RI Certification of Authorization number.

See attached letter.

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

This proposal will be in compliance with all applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

4. Does the construction, renovation or use of space described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems: Yes____ No **X**

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

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

Alternative 1: Do nothing, and continue to transport ED patients requiring MRI to the Radiology Department. The existing unit in the Davol building (pediatric imaging suite) is located about 340 feet away and is one floor level below, and the existing units in the Grosvenor building is about 1120 feet away. Both locations would continue to involve the transport of the patient through various corridors that have public traffic. Due to the distances, utilization of the existing units the hospital does not see this option as a viable solution.

Alternative 2: Continue to use CT as an alternative to MRI. ED patients would continue to be exposed to higher levels of radiation than would be necessary in those cases where a CT scan was used rather than waiting for a slot on one of the existing MRI units.

<u>Alternative 3</u>: Acquire and install an MRI unit in the ED. This is the most efficient alternative to meet the MRI needs of ED patients, and provides continuity of care in a consistent environment without the patient having to travel lengthy distances to other parts of the hospital. This alternative will also enhance safety by reducing the number of ED patients given a CT scan with a higher level of radiation in lieu of waiting for an MRI, and will free up slots on the existing MRI units for inpatients and outpatients.

<u>Alternative 4</u>: Acquire and install an MRI unit in a location adjacent to the ED. This alternative would still involve the transportation of patients to other areas of the hospital. The two closest locations are the MOC and Davol buildings, neither of which was designed to accommodate an MRI and pose construction (structural) challenges. Patients would still have to be transported which would not be beneficial for their care, and the reduction in the use of CT as an alternative to MRI would not be as significant as it would be with alternative 3.

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

The proposed equipment acquisition will be sited within the existing RIH owned building.

7. If zoning approval is required, attach evidence of application for zoning approval.

Not needed.

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

Not Needed.

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

Three months after approval

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

January, 2013

11. Describe the arrangements that have been made for architectural services, including the name, address of the architect, RI Registration Number and RI Certification of Authorization number.

Rhode Island Hospital Facilities Management Design Team
17 Virginia Ave. Providence, RI. 02905
Ricardo L. Quiterio, Reg. number 2289

Change in Space Form Instructions

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

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

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

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

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

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

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

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

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

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

Change in Space Form

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

Gross Sq. Ft.

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
Bridge Building ED storage space	**725**	**0**	**0**	**725**	**0**	**-725**
Bridge Building ED equipment room	**340**	**0**	**325**	**340**	**325**	**-15**
Bridge Building ED rad. holding bay	**135**	**0**	**0**	**135**	**0**	**-135**
Bridge Building ED rad. Room	**295**	**0**	**0**	**295**	**0**	**-295**
New MRI room zone 4	**0**	**0**	**355**	**0**	**355**	**+355**
New MRI prep-room zone 3	**0**	**0**	**195**	**0**	**195**	**+195**
New MRI equip. room	**0**	**0**	**340**	**0**	**340**	**+340**
New MRI control room	**0**	**0**	**210**	**0**	**210**	**+210**
New MRI tech room	**0**	**0**	**70**	**0**	**70**	**+70**
TOTAL:	**1495**	**0**	**1495**	**1495**	**1495**	**0**

Rhode Island Hospital

A Lifespan Partner

RIH - Design Team

17 Virginia Avenue
Suite 101
Providence, RI 02905

Tel 401 444-8000
Fax 401 444-8902

October 31, 2011

Raymond Rusin
Chief of Division of Facilities Regulations
Department of Health
Cannon Building
Three Capitol Hill
Providence, RI 02908-5097

RE: Rhode Island Hospital
Bridge Building MRI CON
Located in Bridge Building, 1st floor
WO #295824, Proj. # 12-109

In conformance with the department of health requirement identified in Appendix D of the certificate of need documents, Rhode Island Hospital notifies the department of health that a preliminary review of the proposed plans has been done by a licensed architect.

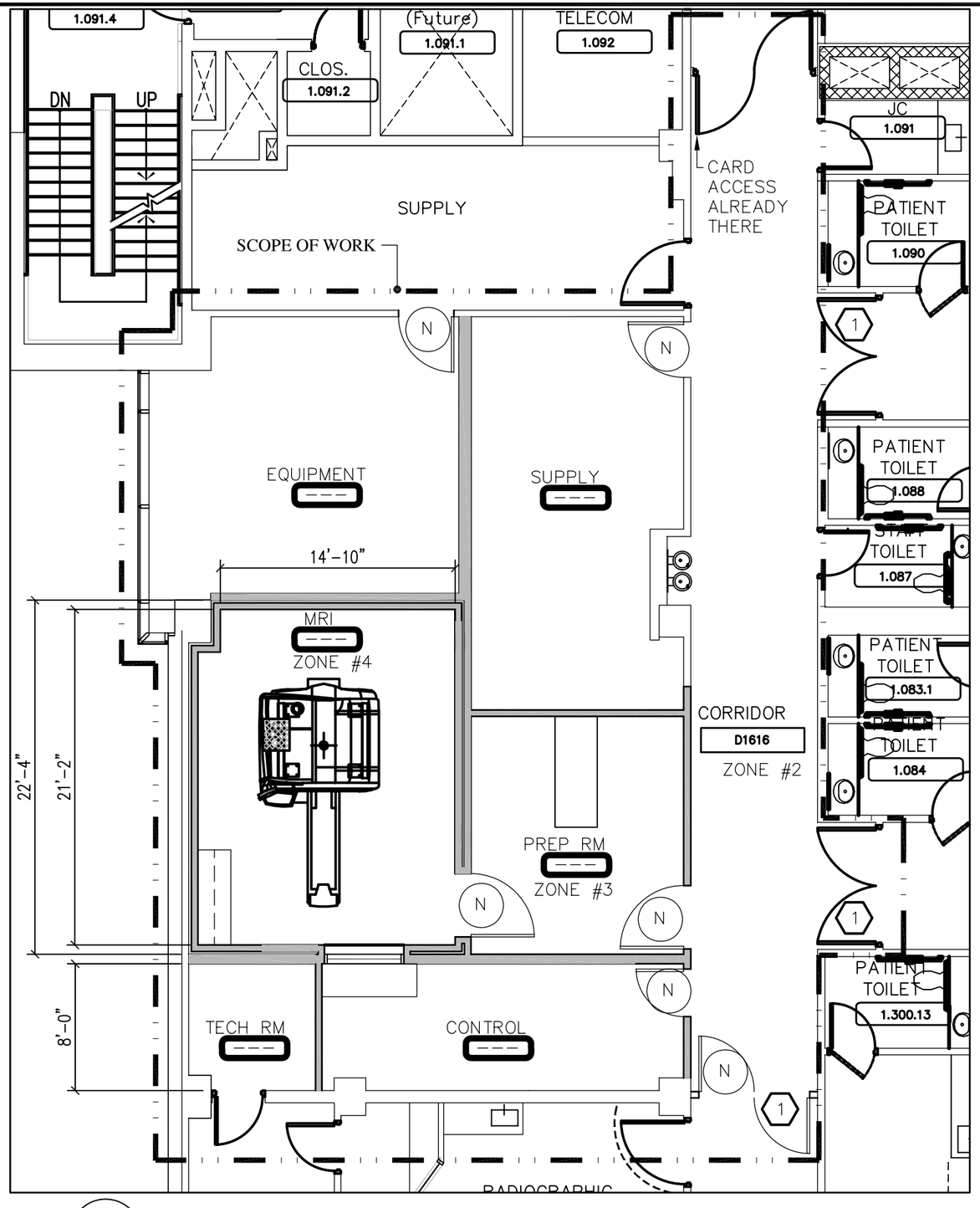
I, Ricardo L. Quiterio, RI License registration #2289, employee of RIH, certify that the proposed plan is in full compliance with the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities, 2006 Edition. The proposed layout complies with Division 2.1 General Hospitals, Sections 5 Diagnostic and Treatment Locations, 5.5 Imaging Suite, 5.5.5 Magnetic Resonance Imaging (MRI).

Feel free to contact me for any inquires, I can be reached at 444-8783.

Sincerely yours

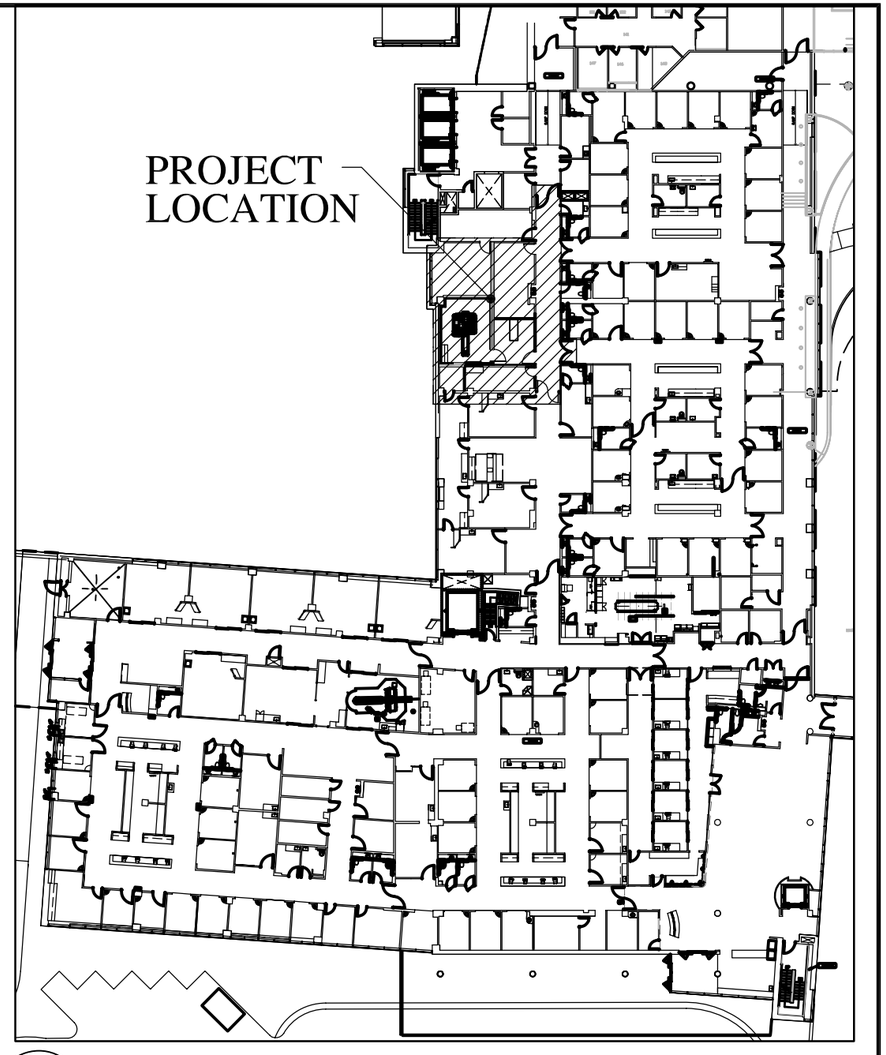
Ricardo L. Quiterio, AIA, CSI, CDT
RI License#2289

CC. RG, G :DOH-reg-CON-letter-RIH-MRI-2011



1 PROPOSED MRI AT BRIDGE BUILDING 1ST FLOOR

SCALE: 1/8"=1'-0"



2 KEY PLAN – MRI– BRIDGE BUILDING 1ST FLOOR

SCALE: 1"=50'-0"

KEY NOTES:

1. PROVIDE AN ACCESS CARD AND PUSH PAD TO EXISTING AND NEW DOOR FOR SECURITY CONTROL.

Rhode Island Hospital
A Lifespan Partner

Facilities Management Department
593 Eddy Street
Providence, RI 02903
Tel: (401) 444-8000
Fax: (401) 444-8599

No.	Date	Remarks
Revisions		

Sheet Title
PROPOSED FLOOR PLAN

Project Title
MRI AT BRIDGE BUILDING
BRIDGE BUILDING 1ST FLOOR

Project Information
W.O. No.:W. SKETCHES
Date: 09/21/11
File No.: W. SKETCHES
Drawn By: MG
Checked By: RQ
Scale: AS NOTED

Drawing No.
SKA-1

Appendix E

Acquisition of Health Care Equipment Valued in Excess of $2,250,000 or Tertiary/Specialty Care Equipment

Complete separate copies of this appendix for each piece of such equipment contained in this application.

1. Identify the proposed equipment (and current if it is being replaced) and at least two similar alternative makes or models that were considered for acquisition in the following format

	Current Equipment	Proposed Equipment	Alternative 1	Alternative 2
Type of Equipment	**N/A**	**1.5 MRI**	**1.5T MRI**	**1.5 MRI**
Name of Manufacturer	**N/A**	**Siemens**	**Toshiba/**	**Philips**
Make and Model Number	**N/A**	**Aera**	**Titan/**	**Ingenia**
Capital Cost of Equipment	**N/A**	**$1,750,000**	**$1,750,000**	**$1,750,000**
Operating Cost	**N/A**	**$1,400,000**	**$1,400,000**	**$1,400,000**

2. Describe the clinical application for which the proposed equipment will be used.

   MRI scans within the Emergency Department.

3. Please identify the reasons the alternative two options were rejected in favor of the proposed equipment.

   The proposed unit is being purchased in connection with other imaging equipment, and while all of the proposals are acceptable, the proposal from Siemens is more compatible with existing RIH imaging equipment.

4. If the proposal is to replace current existing equipment, please provide the following information:

	Current Equipment
Date of Acquisition	**N/A**
Expected Salvage Value	**N/A**
Remaining Useful Life	**N/A**
Method of disposition	**N/A**

5. Please state below the number of new full-time equivalent personnel by job category whom you will hire in order to operate the proposed equipment.

Job Category	Number of FTE's	Payroll Expense
MRI Technicians	**4.5**	**$377,341**

6. Please describe below your anticipated utilization for this equipment for each of the three fiscal years following acquisition of this equipment.

Projected	FY **2013**	FY **2014**	FY **2015**	FY **2016**
Hours of Operation	**8,760**	**8,760**	**8,760**	**8,760**
Utilization (#) Exams	**3,997**	**5,724**	**6,195**	**6,677**
Throughput Possible (#) Exams	**6,570**	**8,760**	**8,760**	**8,760**
Utilization Rate (%) Exams	**60.8%**	**65.3%**	**70.7%**	**76.2%**
Operational Utilization Rate (%) Exams*	**61%**	**71%**	**73%**	**78%**

***Operational utilization is a calculation of the utilization of the MRI units during the peak hours of 7am to 9pm, which take into consideration both specialty exams which require longer periods of time, such as functional MRI or pediatric MRI requiring sedation, and block times required to coordinate MRI with other procedures such as cyber knife.**

Appendix G

Ownership Information

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

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

   See Table 1 at end of this Appendix

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

   See Table 1 at end of this Appendix

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

   See Table 1 at end of this Appendix

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

   - If response 4 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

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

   See Chart after Table 1 at end of this Appendix

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

See Table 2 at end of this Appendix

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

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

8. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 or 6 above during the last 5-years had bankruptcies and/or were placed in receiverships? Yes___ No **__X__**

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

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

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

Not Applicable, as no new entity is being proposed.

TABLE 1 – RESPONSE TO QUESTIONS 1, 2 & 3

LIFESPAN

Name	Address	Other Healthcare Interests	Business Interest with Lifespan
Sister Therese M. Antone	O: Salve Regina University 100 Ochre Point Avenue Newport, RI 02840 Telephone: (401) 341-2337 Fax: (401) 847-4150	None	None
Lawrence A. Aubin	O: Aubin Corp., 1460 Fall River Avenue Seekonk, MA 02771 Telephone: 508-336-4000 Fax: 508-336-3241:	None	None
Mr. David A. Brown	O: President, Whittet-Higgins Co., 33 Higginson Avenue, Central Falls, RI 02863 Telephone: (401) 728-0700 Fax: (401) 728-0703 H: 15 Bond Road, Riverside, RI 02915	None	None
Mr. Peter Capodilupo	O: BMW of Newport, 1215 West Main Road, Middletown, RI 02842 Telephone: (401) 846-6640 Fax: (401) 842-0434 H: 1 Avenir Court, Bristol RI, 02809	None	None
George D. Caruolo, Esq.	O: Attorney at Law, 670 Willett Avenue, East Providence, RI 02915 Telephone: (401) 437-0905 Fax: (401) 437-3618 H: 1 Goodall Place, Riverside RI, 02915	None	Compensated Consultant on Government Relations
Michael Ehrlich, M.D.	O: Surgeon-in-Chief, Dept. of Orthopedics, 2 Dudley Street, 1st floor – Room 170.36, Providence RI, 02903 Telephone: (401) 444-5895 Fax: (401) 444-6243 H: 112 Sudbury Road, Concord MA, 01742	President, University Orthopaedics and RIH Orthopedic Foundation	Compensated as Rhode Island Hospital Chief of Orthopedics for administrative, service, and teaching services

Name	**Address**	**Other Healthcare Interests**	**Business Interest with Lifespan**
Jonathan Fain	O: President, Teknor Apex Company 505 Central Avenue, Pawtucket, RI 02861 Telephone: (401) 725-8000 Fax: (401) 726-0341	None	None
Edward Feldstein, Esq. (ex officio)	O: Roberts Carroll Feldstein & Pierce, Inc. 10 Weybosset Street, Providence, RI 02903 Telephone: (401) 521-7000 Fax: (401) 521-1328	None	Provides Legal Services, President of Roberts, Carroll, Feldstein & Pierce
Ms. Armeather Gibbs	O: United Way of RI, 50 Valley Street, Providence RI, 02909 Telephone: (401) 444-0613 Fax: (401) 444-0635 H: 4 Arbor Drive, Providence RI, 02908	None	None
Marie J. Langlois	O: Managing Director Washington Trust Investors, 68 South Main Street, Providence, RI 02903 Telephone: (401) 654-4806 Fax: (401) 751-4575	Tockwotton Home Board	None
Mr. Scott B. Laurans**	O: President, ESM Incorporated, 35 Barberry Hill, Providence RI, 02906 Telephone: (401) 331-6250 Fax: (401) 331-7014	None	None
Stephen P. Massed (ex officio)	O: Purvis Systems, Inc. 1272 W. Main Road, Middletown, RI 02842 Telephone: (401) 845-8423 Fax: (401) 849-0121	None	None
Charles J. McDonald, M.D.	O: Dermatologist in Chief, RI Hospital –APC 10, 593 Eddy Street, Providence RI, 02903 Telephone: (401) 444-7137 Fax: (401) 444-7105 H: 433 Poppasquash Road, Bristol RI, 02809	President, Dermatology Foundation of RI, Inc.	Compensated as Rhode Island Hospital Chief of Dermatology for admini-strative, service, and teaching services

Name	**Address**	**Other Healthcare Interests**	**Business Interest with Lifespan**
The Honorable Bruce M. Selya	O: Senior U.S. Circuit Judge, 316 Federal Building, 1 Exchange Terrace, Providence RI, 02903 Telephone: (401) 752-7140 Fax: (401) 752-7150 H: 224 George Street, Providence RI, 02906	None	None
Shivan Subramaniam	O: Chairman & CEO, FM Global 270 Central Avenue Johnson, RI 02919 Telephone: (401) 275-3000 Fax: (401) 464-8928	None	Chairman & CEO, FM Global Insurance Company. Lifespan purchases property & Casualty insurance from FM Global
George Vecchione President and CEO Lifespan Corporation	O: Lifespan Corporation, CORO Building, 167 Point Street Providence, RI 02903 Telephone: 401-444-6699 Fax: 401-444-8700	Board Member Hospital Association of RI and RI Quality Institute	President and CEO
Alfred J. Verrecchia* Chairman of the Board	O: Hasbro, Inc., 1011 Newport Avenue, Pawtucket, RI 02860 Telephone: 401-727-5100 Fax: 401-721-7202	None	None

* Chair
** Vice Chair

RHODE ISLAND HOSPITAL

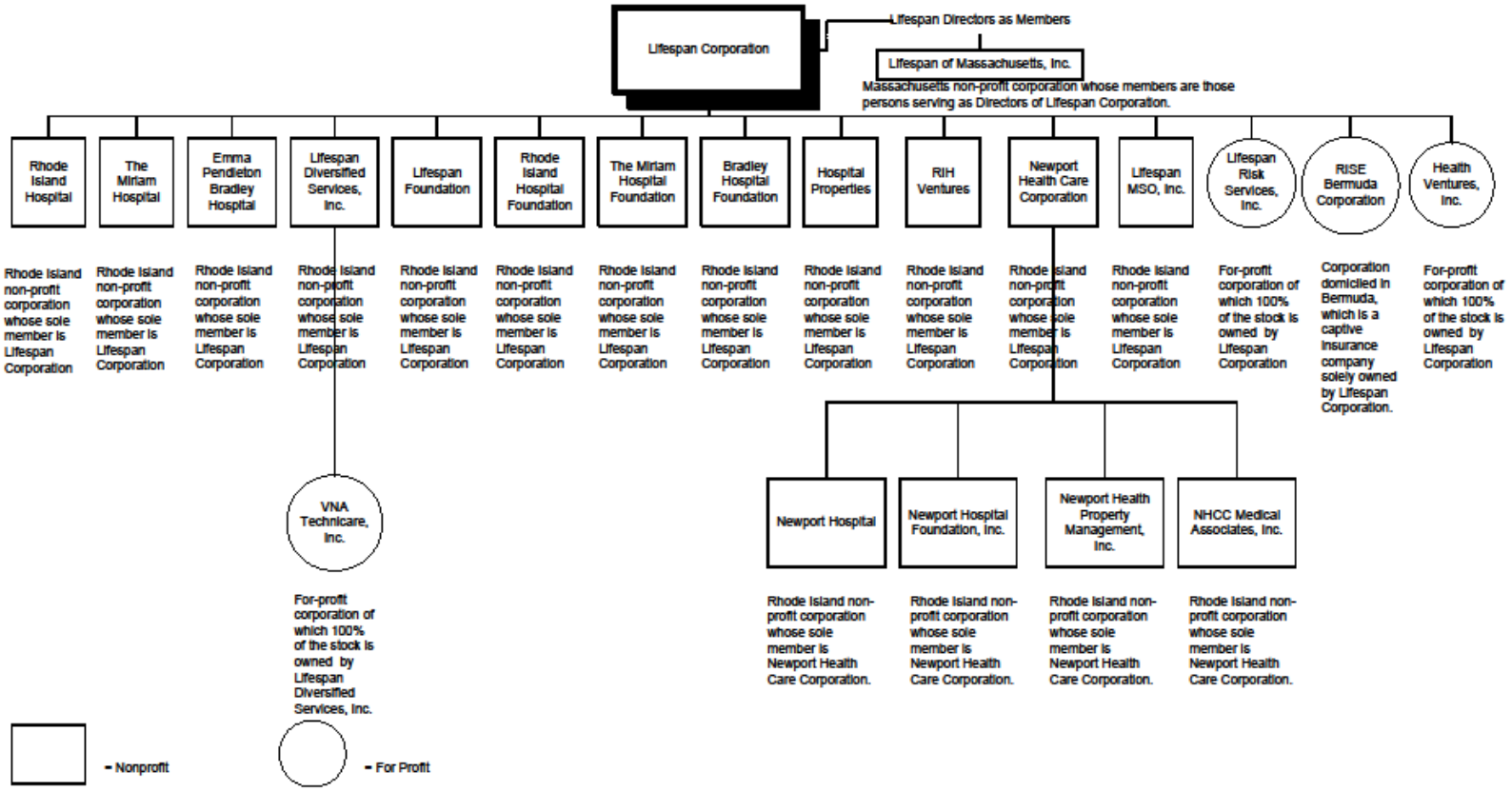
Name	Address	Other Healthcare Interests	Business Interest with RIH
Lawrence A. Aubin (Chairman)	O: Aubin Corp., 1460 Fall River Avenue Seekonk, MA 02771 Telephone: 508-336-4000 Fax: 508-336-3241:	Lifespan Board of Directors	None
Edmund C. Bennett (Vice Chair)	O: 50 South Main Street Providence, RI 02903 Telephone: 401-421-1150 Fax: 401-521-4080	Trustee, the Episcopal Housing Foundation of RI; Hallworth House Nursing facility is a division	None
Emmanuel Barrows	O: Bank of RI, One Turks Head Place Providence, RI 02903 Telephone: 401 456-5015 Fax: 401 456-5021	None	None
Ellen A. Collis (Ex-officio)	O: 233 Rumstick Point Road Barrington, RI 02806-4923 Telephone: 401-245-4043 Fax: 401-245-4076	None	None
Michael Hanna (Treasurer)	O: Sullivan & Company 50 Holden Street Providence, RI 02903 Telephone: 401 272-5600, x133	None	None
Timothy J. Babineau, MD	O: Rhode Island Hospital, 593 Eddy Street Providence, RI 02903 *Telephone: 401 444-5131*	None	President/CEO – RIH
Jeffrey G. Brier (Ex-officio)	O: Brier & Brier, One Richmond Square, Providence, RI 02903 Telephone: 401 751-2990 Fax: 401 351-8347 H: 4 Harian Road, Providence, RI 02906	Board Member Hospital Assoc of RI	Wife employee of TMH – Son employee of Lifespan Corporation
Jane Williams, RN, PhD (Secretary)	O: Rhode Island College, College of Nursing, Providence, RI 02908 Telephone: 401-456-8014 Fax: 401-456-8206	Chair and Professor of Nursing, Rhode Island College; and interim Dean	None

Name	Address	Other Healthcare Interests	Business Interest with RIH
Edward D. Feldstein, Esq. (Ex-officio)	O: Roberts Carroll Feldstein & Pierce, Inc. 10 Weybosset Street Providence, RI 02903 Telephone: (401) 521-7000 Fax: (401) 521-1328	None	Provides legal services to Lifespan President of Roberts, Carroll, Feldstein & Price
Penelope H. Dennehy, MD	O: Rhode Island Hospital, 593 Eddy Street, POB 018, Providence, RI 02903 Telephone: 401 444-8360 Fax: 401 444-5650	None	RIH Director – Division of Pediatric Infectious Diseases
Joseph J. MarcAurele	H: 130 Fox Run East Greenwich, RI 02818-5100	None	None
Michael J. Perik	O: Princeton Review 111 Speen Street Street, Ste 550 Framingham, MA 01701-2090 Telephone: 508-663-5094	None	None
James A. Procaccianti	O: 1140 Reservoir Avenue Cranston, RI 02920-6054 Telephone: 401-946-4600 Fax: 401-943-7338	None	None
Brian J. Zink, MD	O: Rhode Island Hospital Emergency Medicine 55 Claverick Street, Providence, RI 02903 Telephone: 401 444-5141 Fax: 401444-5118	President of University Emergency Medicine Moundation	Chair, RIH Dept. of Emergency Medicine
George A. Vecchione *(ex officio)*	O: Lifespan Corp., 167 Point Street, Ste. 2B Providence, RI 02903 Telephone: 401-444-6699 Fax: 401-444-8700	None	President and CEO, Lifespan Corporation
Alfred J. Verrecchia *(ex officio)*	O: Hasbro, Inc., 1011 Newport Avenue Pawtucket, RI 02860 Telephone: 401-727-5100 Fax: 401-721-7202	None	President and CEO, Hasbro, Inc., a donor to RIH

Name	Address	Other Business Interests	Business Interests With RIH
Jonathan J. Elion	O: 2255 Commodore Perry Highway Wakefield, RI 02879-3940 Telephone: (401) 473-2001 Fax: (401) 284-1333	President & CEO ChartWise Medical Systems Member, Miriam Cardiology, Inc.	None
Brian Goldner	O: 1011 Newport Avenue Pawtucket, RI 02860 Telephone: (401) 727-5204 Fax: (401) 721-7244	None	None
Dayle H. Joseph, M.S., Ed.	O: 2 Heathman Road Kingston, RI 02881 Telephone: (401) 874-5301 Fax☹401) 874-3811	Board Secretary RI Free Clinic; BCBS	None
Mary Jo Kaplan	O: 283 Wayland Avenue Providence, RI 02906 Telephone: (401) 421-4886	Husband physician/ partner North Main Radiation Oncology	Husband on medical staff of RIH and TMH
Phillip Kydd	O: Room 210, Two Capitol Hill Providence, RI 02903 Telephone: (401) 222-2481, ext. 4003 Fax: (401) 222-6168	Wife salaried employee of Brown University	None
Bertram M. Lederer	O: 505 Central Avenue Pawtucket, RI 02861 Telephone: (401) 725-8000 Fax: (401) 729-0166	None	None
Alan H. Litwin .	O: 951 North Main Street Providence, RI 02904 Telephone: (401) 274-2001 Fax: (401) 831-4018	None	None
David A. Marcoux, MD	O: 407 East Avenue, Suite 120 Pawtucket, RI 02860 Telephone: (401) 725-4760 Fax: (401 725-4740	Physician	None

Name	Address	Other Business Interests	Business Interests With RIH
Fred J. Schiffman, MD	O: 164 Summit Avenue Providence, RI 02906 Telephone: (401) 793-4035 Fax: (401) 793-4049	Physician	None

Corporate Structure



May 25, 2007

TABLE – - RIH AND SISTER ENTITY FACILITIES

1. **A. Emma Pendleton Bradley Hospital**
   B. 1011 Veterans Memorial Parkway
   East Providence, RI 02915
   C. Hospital License #: HOS00123
   D. Medicare Provider #: 41-4003
   E. Professional Accreditations: JCAHO

2. **A. Bradley Research Center**
   B. 1 Hoppin Street
   Providence, RI 02903
   C. Hospital License #: HOS00123-01
   D. Professional Accreditations: JCAHO

3. **A. The Miriam Hospital**
   B. 164 Summit Avenue
   Providence, RI 02906
   C. Hospital License #: HOS00122
   D. Medicare Provider #: 41-0012
   E. Professional Accreditations: JCAHO and CAP

4. **A. TMH Laboratory**
   B. 1 Hoppin Street
   Providence, RI 02903
   C. Hospital License #: HOS00122-03
   D. Professional Accreditations: CAP

5. **A. TMH Laboratory**
   B. 1 Commerce Street
   Lincoln, RI 02865
   C. Hospital License #: HOS00122-04
   D. Professional Accreditations: CAP

6. **A. TMH Laboratory**
   B. 400 Bald Hill Road
   Warwick, RI 02886
   C. Hospital License #: HOS00122-05
   D. Professional Accreditations: CAP

7. **A. RISE TB Clinic**
   B. 14 Third Street
   Providence, RI 02906
   C. Hospital License #: HOS00122-06
   D. Professional Accreditations: JCAHO

8. A. TMH Behavioral Medicine Clinic
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00122-07
D. Professional Accreditations: JCAHO

9. A. TMH Immunology Research Center
B. 14 Third Street and 11 Fourth Street
Providence, RI 02906
C. Hospital License #: HOS00122-08
D. Professional Accreditations: JCAHO

10. A. TMH Weight Control & Diabetes Research Center
B. 196 Richmond Street
Providence, RI 02903
C. Hospital License #: HOS00122-10

11. A. TMH Outpatient Rehabilitation Services
B. 195 Collyer Street
Providence, RI 02904
C. Hospital License #: HOS00122-11
D. Professional Accreditations: JCAHO

12. A. TMH Cardiac Rehabilitation/Pulmonary Rehabilitation Center
B. 208 Collyer Street
Providence, RI 02904
C. Hospital License #: HOS00122-12
D. Professional Accreditations: JCAHO

13. A. TMH Diagnostic Imaging Center
B. 195 Collyer Street
Providence, RI 02904
C. Hospital License #: HOS00122-13
D. Professional Accreditations: JCAHO

14. A. TMH Pre-admission Testing Center
B. 208 Collyer Street
Providence, RI 02904
C. Hospital License #: HOS00122-14
D. Professional Accreditations: JCAHO

15. A. Newport Hospital
B. 11 Friendship Street
Newport, RI 02840
C. Hospital License #: HOS00127
D. Medicare Provider #: 41-0006
E. Professional Accreditations: JCAHO, CARF, and CAP

16. A. Jamestown Family Practice Center (Offices of Drs. J. England and K. Murray)
B. 20 Southwest Avenue
Jamestown, RI 02835
C. Hospital License #: HOS00127-01
D. Professional Accreditations: JCAHO, CARF, and CAP

17. A. Family Physicians of Tiverton/Little Compton (Offices of Drs. W. Keigwin and J. Miniutti)
B. 1800 Main Road
Tiverton, RI 02878
C. Hospital License #: HOS00127-03
D. Professional Accreditations: JCAHO, CARF, and CAP

18. A. Family Physicians of Newport (Offices of Drs. D. Derolf and W. Levin)
B. 19 Friendship Street
Newport, RI 02840
C. Hospital License #: HOS00127-04
D. Professional Accreditations: JCAHO, CARF, and CAP

19. A. Rhode Island Hospital
B. 593 Eddy Street
Providence, RI 02903
C. Hospital License #: HOS00121
D. Medicare Provider #: 41-0007
E. Professional Accreditations: JCAHO and CAP

20. A. RIH Outpatient Psychiatry
B. 235 Plain Street
Providence, RI 02905
C. Hospital License #: HOS00121-01
D. Medicare Provider #:
E. Professional Accreditations: JCAHO and CAP

21. A. RIH Lab at the Office of Louis J. Moran, M.D.
B. 1035 Post Road
Warwick, RI 02886
C. Hospital License #: HOS00121-04
D. Professional Accreditations: CAP

22. A. RIH Lab at the Office of Hugo Yamada, M.D.
B. 6 Blackstone Valley Place
Lincoln, RI 02865
C. Hospital License #: HOS00121-05
D. Professional Accreditations: CAP

23. A. Rhode Island Hospital Child Research Center
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00121-08

24. A. Rhode Island Hospital Outpatient Rehabilitation Services
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00121-09
D. Professional Accreditations: JCAHO and CAP

25. A. Hallett Center for Diabetes & Endocrinology
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00121-10
D. Professional Accreditations: JCAHO and CAP

26. A. RIH Pediatric Heart Center
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00121-11
D. Professional Accreditations: JCAHO and CAP

27. A. RIH Pediatric Asthma/Allergy & Specialty Center
B. 1 Hoppin Street
Providence, RI 02903
C. Hospital License #: HOS00121-12
D. Professional Accreditations: JCAHO and CAP

28. A. RIH Sleep Disorders Center
B. 70 Catamore Boulevard
East Providence, RI 02914
C. Hospital License #: HOS00121-13

29. A. RIH Pediatric and Adolescent Health Care Center
B. 1 Hoppin Street
Providence, RI 02903
HOS00121-14

30. A. RI Hospital Hasbro Children's Outpatient Rehab Services
B. 765 Allens Avenue
Providence, RI 02903
HOS00121-15

32. A. General Internal Medicine Research Group
B. 111 Plain Street
Providence, RI 02902
HOS00121-16

ATTACHMENT 1 - RIH FINANCIAL ASSISTANCE POLICY

Lifespan Corporate Service and it's Affiliate Hospitals

Subject:
Financial Assistance Policy

File Under:

Original Procedure Date:
August 16, 1996

Latest Revision Date:
June 1, 2009

Approved By:

_____

Nadeen LaFleur, Director PFS

_____

Ann Kashmanian, Vice President Finance

Purpose

To ensure that all indigent, uninsured patients, who are residents of the U.S.A. receive the essential medical services needed at a reduced rate (partial or full financial assistance). Non-residents of U.S.A., who are visiting the country, are eligible for emergent service and non-residents who are living permanently in the U.S.A. may be considered for full or partial assistance.

Lifespan Affiliate Hospitals will not deny any patient necessary medical care and treatment. If a patient is unable to pay for health care services, he/she may be eligible for free healthcare or healthcare at a reduced rate. This policy is subject to the rules and regulations promulgated, from time to time, by the Affiliate Hospital's Board of Trustees.

Patients are responsible for certain Physicians' fees, Anesthesiologist's fees, charges for the interpretation of certain tests/x-rays and all other services delivered by other providers. Patients are also responsible for non-covered services such as private room differentials that are not essential medical services. The designated Financial Medical Advisor at each affiliate site will provide guidance as needed to determine essential medical services of specific services or programs. Some services are not covered (Rhode Island Hospital Cosmetic Services, Sports Rehabilitation self referrals, Hearing Aids, Children's Rehabilitation Constraint Therapy Program and some Dental procedures - Occlusal Guards for bruxism, Laboratory fabricated veneers, Fixed bridgework of 4 or more units, Dental Implants, and Bleaching of teeth, **Orthodontic Treatment, Posterior composite fillings**). The following Dental procedures would qualify

for a 50% CFS reduction only: Full mouth series of x-rays for comprehensive treatment planning, Full upper and lower dentures, Partial upper and lower dentures, Root canals, Porcelain fused to metal crowns and post & core, Periodontal scaling and root planing, Periodontal surgery, Prophylaxis (cleaning), **Restorations (amalgam and composite) exception: if referred from Oncology, Transplant, and Craniofacial Clinics the procedure qualifies up to 100% deduction..**

The Miriam Hospital Cosmetic Surgery. Cardiac Rehabilitation Maintenance and Weight Management services may be determined to be essential medical services if established medical criteria/guidelines are met with required documentation specific to the program. - Newport Hospital Cardiac Rehabilitation and Cosmetic Surgery.) In the event a patient refuses a medically safe and appropriate discharge plan and agreement cannot be reached, the hospital will hold the patient financially responsible for the continued hospital stay and will not qualify for LCS Financial Assistance Program.

Financial Assistance Policy:

LCS Financial Assistance Policy is available based upon immediate family's estimated gross income from all sources before taxes:

- Uninsured patients receive an automatic 50% partial Community Benefit/Charity Care deduction as a commitment by Lifespan to the uninsured patients at RIH, TMH and Newport and a 25% Community Benefit deduction at Bradley Hospital. *The 50% discount applies to all uninsured patients provided, however, that the Charity Care Benefit does not block an individual patient's ability to qualify for the State's Medicaid program.* Massachusetts' residents only qualify for a 50% reduction. (**Exception – Massachusetts' patients transferred to RIH/TMH Emergency Department or to an Inpatient Nursing Unit can apply for CFS for both services in addition to outpatient follow up related to the transfer diagnosis. Patients who may qualify for Mass Health must apply and if they are denied can apply for CFS.)**

Children over 18 years of age claimed as a dependent on their parents/guardian's taxes the parents/guardian's income is included to determine CFS eligibility.

- Insured Patients – Medicare Patients including Senior Products

Waivers of cost-sharing amounts for financially needy Medicare Beneficiaries: A discount offered to a Medicare beneficiary generally takes the form of a waiver of all or a portion of the Medicare program co-payment or deductible, that is, the portion of the bill that the beneficiary owes. While generally banning routine cost-sharing waivers, such "insurance" billing and the like, the Congress recognized that some beneficiaries might not be able to afford their cost-sharing amounts. Lifespan allows exception for waivers on the basis of financial need. The exception includes three requirements:

1) the waivers are not routine
2) the waivers are not offered as part of any advertisement or solicitation
3) the waivers may only be made after in good faith as evidenced by the completion of a Charity Free Care Application

The affiliate hospital will waive payments, in part or in full, for necessary medical services provided for eligible applicants.

The Patient Advocates (PFA'S)/Patient Financial Counselors (PFC'S) at Lifespan Hospitals will explore sources of funds from special programs that may be available on an individual patient need basis.

Eligibility for CFS above the 50% is provided for those applicants whose family gross income is at or below the Income Guidelines (see attachment) effective on the date the patient applies for financial assistance. For patients who qualify for less than 100% of the financial assistance program, the patient may be offered a payment plan – refer to *Lifespan Affiliate Hospital's Patient Payment Policy*.

II. Procedure for Financial Assistance:

1. Applications for the Financial Assistance program are available in the Admitting Office, Emergency Departments, Business Office, Patient Financial Advocate's Office, Patient Financial Counselor's Office, Patient Financial Services and all Outsource Agencies offices. Assistance to complete the form is available with the Patient Financial Advocates/Patient Financial Counselors. The patient/patient's family may either schedule an appointment with, or walk-in to see a Patient Financial Advocate/Patient Financial Counselor. Patients can also receive assistance by calling the Patient Financial Services Customer Service Department when they have received a bill for charges previously incurred.

2. Applicants are required to have family income information available with proof of income documents: W-2 forms, most *current annual tax forms*, at least two pay stubs, copy of savings and checking accounts statements, copy of photo identification and any other income documentation such as a copy of a check for Veteran's Benefits are **required**, along with a denial letter from Medical Assistance and proof of residence. A denial letter from Medical Assistance may not be required when non-eligibility can be pre-determined by the Patient Financial Advocate/Patient Financial Counselor for those patients who clearly do not meet the Medical Assistance requirements. (Exceptions: in situations where there is no income, a self-declaration, notarized letter from the patient, or person supporting the patient may be accepted).

   Documentation is required for Non-residents, who are living permanently in the U.S.A. This includes a copy of their most current annual tax forms, W-2 forms, at least the last two pay stubs, proof of residency and photo identification. If the patient has a Social Security number/Tax identification number (TIN) and the patient does not file taxes a credit report may be obtained. (Patients without a Social Security number or TIN number will provide a notarized letter explaining their living situation and a notarized letter from the person who is supporting them, including proof of residency) Documentation is required for patients visiting the U.S.A. when applying for Financial Assistance. A copy of a passport or visa, a self-declaration notarized letter explaining their income from their residing country and a self-declaration notarized letter from the family supporting them while in the USA.

Homeless patients having an Emergency Room visit, a Financial Assistance application will be completed and signed. Documentation is not required. The Emergency Department CFS plan code will be added to the patient's account. The application is valid for the ED Visit only. If an Inpatient and/or an Outpatient are homeless, the Patient Financial Advocate/Patient Financial Counselor will explore sources of funds from special programs that may be available on an individual patient basis. If the patient does not qualify for any program, the Financial Assistance application will be completed, a letter from the shelter, if any, will be required or a self declaration letter from the patient explaining how he/she supports himself/herself, a credit report and copy of their current tax forms and at least the last two pay stubs if applicable. (Patients at times will not be able to acquire a copy of their taxes, because of residency, the credit report and a notarized letter from the patient explaining living arrangements will be accepted.)

Documentation required for self-employed patients *may include* the most current year tax return, credit report, a self-declaration notarized letter with monthly expenses and proof of expenses, (copy of monthly bills).

3. All completed applications, along with supporting documentation will be forwarded to the Patient Financial Services (PFS)-Customer Service Department to be filed away UNLESS the affiliate hospital has scanning capabilities, then the applications will be scanned by that affiliates designated staff and NO hard copy will be sent to PFS Customer Service Department.

   All approved or denied applications should be documented in SMS ***History*** Comments section. If the application is approved for full or additional partial, the appropriate financial plan codes are revised to reflect the CFS outcome and the effective dates added for CFS approved coverage duration. A "history" comment will be added by the PFS-Customer Service Staff on the most recent account indicating the effective dates of the CFS and listing the qualified percentage allowed for that duration of time. Denied applications will have the appropriate "denial plan code" added to the account for tracking purposes.

   Patient Financial Advocates, Patient Financial Counselors and Patient Financial Services-Customer Service staffs are responsible for notifying all of the Lifespan Corporate Services Pre-Collection and Collection Agencies of the CFS approval for full or partial coverage.

4. Inpatients with Medicaid pending, the PFA/PFC will complete the Financial Assistance application and RIH staff will provide this to the Medicaid Specialist. If Medicaid is

denied and the patient qualifies for Financial Assistance, the account is revised with the appropriate Siemen's financial plan code.

5. Applications will not be accepted that are dated over 90 days ago from the first patient statement generated. The exception is accounts classified under the "pre-collection agency" or F/C "U" accounts. These applications will not be accepted that are dated 90 days ago from the financial class change date to F/C "U", unless there is a problem with the applicant's third party coverage, pending third party coverage and liability, or if the applicant's financial circumstances have changed. (Patients that have been non-compliant with documentation and after the 90 days they decided to provide the documentation the original date of the application will be accepted.)

6. Approved applications are valid for a period of six-months going forward from the date of the application and six months prior to the approved dates. Exceptions: applications that have balances after Medicare and Medical Assistance and the Immunology Clinic at TMH, Special circumstances cases i.e. chronic homeless, approvals for these exceptions are valid for one year from the date of application. Patients visiting the U.S.A. their application is valid for one day only for outpatient, one admission or follow-up treatment related to the original ED visit only.

7. Checking accounts, saving accounts, insurance policies (cash value), stocks, CD's and mutual fund accounts will need to be within the established saving guidelines for the affiliate hospital. If the saving accounts exceed the established guidelines, the patient needs to spend down the savings towards the affiliate hospital's bill until their saving are within the guidelines.

8. Accounts assigned to bad debt and are found eligible for CFS the accounts will be reactivated from the bad debt status and written off to the CFS appropriate percentage. The Patient Advocates will fax the collection agency a weekly list to update their system and to add to their reports that are sent to the Customer Service Department.

9. Special CFS with Limited Documents:

a) Approval of applications with extenuated circumstances:

Patients that would not be able to provide documents due to their health issues i.e.: severe substance abuse and housing issues who are not associated with a homeless shelter.

Massachusetts Residents who are admitted and expire prior to the Mass Health application being filed. Mass Health will not consider these applications.

Found eligible for Medicaid or GPA have CFS go retro 6 months from date of eligibility if patient does not comply with CFS documentation.

RI resident expires and family will not apply for RI Medicaid.

Patients admitted as self- pay but are taken into State custody during their admission; State (ACI) will pay from date of custody, prior 6 months accounts to be adjusted to CFS

Appeal Process:

Patients have the right to appeal a denied CFS application.
The patient/guarantor must submit their request in writing as to why the patient/guarantor wants to appeal the decision.
The completed application and the supporting documentation with the patient's request to appeal the decision will be forwarded to the Manager or Director of the Patient Financial Advocates.
The Manager/Director will review the appeal letter, original application and supporting documentation for adherence to Lifespan's guidelines. If the patient's financial information has changed from the original application a new application will be completed with the supporting documentation.
The Manager/Director will notify the patient of their decision within ten days of receiving the appeal letter.
If the appeal is denied the patient/guarantor can request a second appeal to the Vice President of Finance.
The patient/guarantor will be notified in writing of the Vice President's decision within ten days of receiving the second appeal letter. If additional documentation is required the patient will receive a decision of the appeal within ten days after receipt of the documentation.

Scope of Application:

Patient Financial Advocates, Patient Financial Counselors, PFS-Customer Service Department and Administration as deemed necessary. All registration personnel at affiliate hospitals and outsourced agencies are responsible to distribute the applications and to refer patients to the PFA, PFS and Customer Service Staff for assistance with applications for financial assistance.

LIFESPAN'S APPLICATION FOR HOSPITAL FINANCIAL-AID *Any approval of this request is temporary and expires 6 months from the date of approval*	
Hospital:	Date:
Patient:	Guarantor/Head of Household:
Date of Birth:	Social Security #(if issued):
Social Security #(if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address: Own/Rent:	Address Own/Rent:
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:
Type of ID & #	Type of ID & #
Is visit related to a work injury or Accident? Yes or No *(If yes, please attach explanation)*	
Are you being claimed as a dependent? Yes or No	
Number of Dependents (including self):	
Have you ever applied for Medical, Rite Care or Public assistance? Yes or No	Are you an American Citizen? Yes or No
Please provide the following information for ALL members of the family unit (if they are not listed on the Federal Income Tax Form).	
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address	Home Address:
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address	Home Address:
Monthly Income	**Assets**
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Guarantor's Salary & Wages:	Money Market Accounts:

Child Care Income:	Saving Bonds:	
Rental Income:	Stocks:	
Unemployment Compensation:	Bonds:	
Temporary Disability Insurance:	Mutual Funds:	
Monthly Income Cont.:	**Assets Cont:**	
Child Support:	IRAs**:**	
Alimony:	401(k)s:	
Workers' Compensation:	403(b)s:	
VA Benefits:	457s:	
Social Security Payments:	Cash-In Value Life Insurance:	
Dividend & Interest Income:	Personal Property:	
Royalties:	2nd Home & Rental Property:	
Pensions:	2nd Motor Vehicle:	
Public Assistance:		TOTAL:
Other:		
Monthly Income: Total Monthly Expenses:		
Annual Income:		
IF YOU LIST NO INCOME WHAT HAS BEEN YOUR SOURCE OF SUPPORT? Use separate sheet of paper if needed.		

Please be sure to enclose a copy of your most recent Federal Income Tax Filing and the last two paycheck stubs.

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."	
Signature:	Date:

Applicants are required to have family income information available with proof of income documents: W-2 forms, most *current annual tax forms*, at least two pay stubs, copy of savings and checking accounts statements, copy of photo identification and any other income documentation such as a copy of a check for Veteran's Benefits are required

Action Taken By The Hospital

CHECK OFF LIST

Pay Stub_____ **Food Stamp Letter_____** **Tax Returns_____**

Credit Report_____ **Other Documentation_____** **Date verified with E.D.S./GPA_____**

If non-Resident required documentation:_____ **Photo ID _____**

Date:_____ **NOT Approved:_____** **Reason:_____**

ATTACHMENT 2
FY'09-FY'11 AUDITED FINANCIAL STATEMENTS

LIFESPAN OBLIGATED GROUP

Combined Statements of Financial Position

September 30, 2009 and 2008

(In thousands)

Assets	2009	2008
Current assets:		
Cash and cash equivalents	$ 107,363	$ 48,455
Patient accounts receivable	205,205	193,429
Less allowance for doubtful accounts	(42,700)	(42,255)
Net patient accounts receivable	162,505	151,174
Other receivables	11,632	11,389
Current portion of contributions receivable, net	3,763	5,607
Total receivables	177,900	168,170
Assets limited as to use	2	1,041
Inventories	15,302	13,990
Prepaid expenses and other current assets	2,312	2,277
Total current assets	302,879	233,933
Assets limited as to use	672,140	630,770
Less amount required to meet current obligations	(2)	(1,041)
Noncurrent assets limited as to use	672,138	629,729
Property and equipment, net	683,307	661,104
Other assets:		
Contributions receivable, net	5,126	6,832
Deferred charges and financing costs, net	9,996	6,999
Other noncurrent assets	8,367	10,445
Total other assets	23,489	24,276
Total assets	$ 1,681,813	$ 1,549,042

Liabilities and Net Assets	2009	2008
Current liabilities:		
Accounts payable	$ 44,615	$ 47,446
Accrued employee benefits and compensation	58,359	44,097
Other accrued expenses	16,548	22,511
Current portion of long-term debt	8,650	4,285
Current portion of estimated third-party payor settlements	30,066	20,229
Estimated health care benefit self-insurance costs	6,361	4,611
Total current liabilities	164,599	143,179
Long-term debt, net of current portion	362,342	256,468
Estimated third-party payor settlements, net of current portion	52,918	54,759
Other liabilities	146,876	69,763
Total liabilities	726,735	524,169
Net assets:		
Unrestricted	614,391	665,278
Temporarily restricted	229,775	142,910
Permanently restricted	110,912	216,685
Total net assets	955,078	1,024,873
Total liabilities and net assets	$ 1,681,813	$ 1,549,042

See accompanying notes to interim combined financial statements (unaudited).

LIFESPAN OBLIGATED GROUP

Combined Statements of Operations and Changes in Net Assets

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2009	2008	2009	2008
Unrestricted revenues and other support:				
Net patient service revenue	$ 328,818	$ 303,903	$ 1,270,432	$ 1,204,445
Other revenue	11,822	13,605	43,704	46,156
Endowment earnings contributed toward community benefit	2,509	2,439	9,482	10,012
Net assets released from restrictions used for operations	3,859	7,399	17,845	17,949
Net assets released from restrictions used for research	18,770	20,832	67,916	73,839
Total unrestricted revenues and other support	365,778	348,178	1,409,379	1,352,401
Operating expenses:				
Compensation and benefits	193,145	180,283	741,232	704,821
Supplies and other expenses	79,339	78,814	303,121	293,972
Purchased services	38,054	38,154	154,959	156,696
Provision for bad debts	18,724	21,693	68,637	72,315
Depreciation and amortization	11,460	10,714	44,885	43,106
Interest	4,913	2,992	15,923	12,107
License fees	13,825	8,289	55,299	33,159
Total operating expenses	359,460	340,939	1,384,056	1,316,176
Income from operations	6,318	7,239	25,323	36,225
Nonoperating gains and losses:				
Unrestricted gifts and bequests	85	100	943	859
Unrestricted (loss) income from board-designated investments	(54)	178	334	1,288
Net realized gains (losses) on board-designated investments	9,425	(6,573)	(15,035)	(14)
Grants to outside agencies	501	(193)	—	(586)
Fundraising expenses	(740)	(1,219)	(3,365)	(3,566)
Other nonoperating (losses) gains, net	(80)	71	(132)	134
Total nonoperating gains (losses), net	9,137	(7,636)	(17,255)	(1,885)
Excess (deficiency) of revenues over expenses	$ 15,455	$ (397)	$ 8,068	$ 34,340

(Continued)

LIFESPAN OBLIGATED GROUP

Combined Statements of Operations and Changes in Net Assets (Continued)

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2009	2008	2009	2008
Unrestricted net assets:				
Excess (deficiency) of revenues over expenses	$ 15,455	$ (397)	$ 8,068	$ 34,340
Other changes in unrestricted net assets:				
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	(71,462)	(6,481)	(71,462)	(6,481)
Effect of changing pension plan measurement date pursuant to FASB Statement No. 158	—	—	(5,226)	—
Net unrealized gains (losses) on investments	8,466	(45,934)	695	(70,067)
Net assets released from restrictions used for purchase of property and equipment	2,045	5,688	14,993	14,436
Other	6	365	2,045	(11)
Decrease in unrestricted net assets	(45,490)	(46,759)	(50,887)	(27,783)
Temporarily restricted net assets:				
Gifts, grants and bequests	22,534	20,492	85,625	90,115
Income from restricted endowment and other restricted investments	575	926	3,350	5,203
Transfers from affiliates	971	162	2,429	1,491
Net assets released from restrictions	(24,674)	(33,919)	(100,754)	(106,224)
Net realized and unrealized gains (losses) on investments	6,735	(20,862)	(7,530)	(25,288)
Appropriations from permanently restricted net assets	—	523	—	2,059
Reclassification from adoption of UPMIFA	103,420	—	103,420	—
Other	(996)	24	325	24
Increase (decrease) in temporarily restricted net assets	108,565	(32,654)	86,865	(32,620)
Permanently restricted net assets:				
Gifts and bequests	66	1,307	1,150	1,687
Net realized gains (losses) on permanently restricted investments	7,062	(1,566)	19	3,779
Net unrealized gains (losses) on investments	2,542	(24,656)	(3,775)	(37,084)
Appropriations to temporarily restricted net assets	—	(523)	—	(2,059)
Reclassification from adoption of UPMIFA	(103,420)	—	(103,420)	—
Other	1,092	—	253	37
Decrease in permanently restricted net assets	(92,658)	(25,438)	(105,773)	(33,640)
Decrease in net assets	(29,583)	(104,851)	(69,795)	(94,043)
Net assets, beginning of period	984,661	1,129,724	1,024,873	1,118,916
Net assets, end of period	$ 955,078	$ 1,024,873	$ 955,078	$ 1,024,873

See accompanying notes to interim combined financial statements (unaudited).

LIFESPAN OBLIGATED GROUP

Combined Statements of Cash Flows

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2009	2008	2009	2008
Cash flows from operating activities:				
Decrease in net assets	$ (29,583)	$ (104,851)	$ (69,795)	$ (94,043)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:				
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	71,462	6,481	71,462	6,481
Effect of changing pension and postretirement plans' measurement date pursuant to FASB Statement No. 158	—	—	5,226	—
Net realized and unrealized (gains) losses on investments	(34,078)	99,591	25,626	128,674
Transfers from affiliates	(971)	(37)	(2,429)	(991)
Permanently restricted gifts and bequests	(66)	(1,307)	(1,150)	(1,687)
Depreciation and amortization	11,460	10,714	44,885	43,106
Provision for estimated health care benefit self-insurance costs	22,551	23,156	85,367	73,953
Decrease in liabilities for estimated health care benefit self-insurance costs resulting from claims paid	(22,050)	(24,024)	(83,617)	(75,502)
Net decrease (increase) in patient accounts receivable	345	1,810	(11,331)	(4,484)
Increase (decrease) in accounts payable	3,594	15,556	(2,831)	1,019
Increase in accrued employee benefits and compensation	8,260	5,606	14,262	4,938
Increase (decrease) in estimated third-party payor settlements	1,676	(5,591)	7,996	(8,428)
Increase (decrease) in all other current and noncurrent assets and liabilities, net	7,672	20,561	(5,621)	16,959
Net cash provided by operating activities	40,272	47,665	78,050	89,995
Cash flows from investing activities:				
Purchase of property and equipment	(17,712)	(31,411)	(66,425)	(98,355)
Net decrease (increase) in trustee-held bond funds	2,155	151	(61,888)	1,193
Other net (increases) decreases in assets limited as to use	(1,825)	7,560	(5,108)	4,640
Net cash used in investing activities	(17,382)	(23,700)	(133,421)	(92,522)
Cash flows from financing activities:				
Proceeds from issuance of long-term debt	—	—	114,985	—
Payments on long-term debt	(1,340)	(1,275)	(4,285)	(1,835)
Permanently restricted gifts and bequests	66	1,307	1,150	1,687
Transfers from affiliates	971	37	2,429	991
Net cash (used in) provided by financing activities	(303)	69	114,279	843
Net increase (decrease) in cash and cash equivalents	22,587	24,034	58,908	(1,684)
Cash and cash equivalents, beginning of period	84,776	24,421	48,455	50,139
Cash and cash equivalents, end of period	$ 107,363	$ 48,455	$ 107,363	$ 48,455

See accompanying notes to interim combined financial statements (unaudited).

KPMG

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Financial Statements

September 30, 2010 and 2009

(With Independent Auditors' Report Thereon)

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Financial Statements

September 30, 2010 and 2009

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KPMG LLP
6th Floor, Suite A
100 Westminster Street
Providence, RI 02903-2321

Independent Auditors' Report

The Board of Trustees
Rhode Island Hospital:

We have audited the accompanying consolidated statements of financial position of Rhode Island Hospital and Affiliates (the Hospital) as of September 30, 2010 and 2009, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Rhode Island Hospital and Affiliates as of September 30, 2010 and 2009, and the results of their operations and changes in net assets, and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As described in note 3 to the consolidated financial statements, in 2009 the Hospital adopted the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Subtopic 958-250, *Classification of Donor- Restricted Endowment Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act.*

KPMG LLP

February 18, 2011

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Financial Position

September 30, 2010 and 2009

(In thousands)

Assets	2010	2009
Current assets:		
Cash and cash equivalents	$ 47,843	$ 81,927
Patient accounts receivable	172,192	147,910
Less allowance for doubtful accounts	(42,876)	(31,301)
Net patient accounts receivable	129,316	116,609
Other receivables	23,179	8,469
Total receivables	152,495	125,078
Assets limited as to use	890	2
Inventories	12,020	11,470
Prepaid expenses and other current assets	2,040	1,901
Total current assets	215,288	220,378
Interest in net assets of Rhode Island Hospital Foundation	50,757	42,552
Assets limited as to use	510,927	449,164
Less amount required to meet current obligations	(890)	(2)
Noncurrent assets limited as to use	510,037	449,162
Property and equipment, net	494,584	489,295
Other assets:		
Deferred charges and financing costs, net	6,911	7,412
Other noncurrent assets	1,733	3,836
Total other assets	8,644	11,248
Total assets	$ 1,279,310	$ 1,212,635

Liabilities and Net Assets	2010	2009
Current liabilities:		
Accounts payable	$ 35,619	$ 32,489
Accrued employee benefits and compensation	32,417	39,579
Other accrued expenses	23,792	12,723
Current portion of long-term debt	7,152	6,851
Current portion of estimated third-party payor settlements	20,146	21,112
Estimated health care benefit self-insurance costs	3,955	4,478
Total current liabilities	123,081	117,232
Long-term debt, net of current portion	263,427	271,108
Estimated third-party payor settlements, net of current portion	42,324	44,327
Accrued pension liability	125,337	97,513
Other liabilities	23,235	23,397
Total liabilities	577,404	553,577
Net assets:		
Unrestricted	413,234	394,666
Temporarily restricted	221,243	207,378
Permanently restricted	67,429	57,014
Total net assets	701,906	659,058
Total liabilities and net assets	$ 1,279,310	$ 1,212,635

See accompanying notes to consolidated financial statements.

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

Years ended September 30, 2010 and 2009

(In thousands)

	2010	2009
Unrestricted revenues and other support:		
Net patient service revenue	$ 918,658	$ 881,533
Other revenue	40,753	34,771
Endowment earnings contributed toward community benefit	7,822	6,570
Net assets released from restrictions used for operations	14,612	15,816
Net assets released from restrictions used for research	52,845	45,023
Total unrestricted revenues and other support	1,034,690	983,713
Operating expenses:		
Compensation and benefits	549,892	519,049
Supplies and other expenses	212,888	198,259
Purchased services	106,245	109,824
Provision for bad debts	54,199	51,126
Depreciation and amortization	33,727	32,698
Interest	14,394	12,094
License fees	41,233	40,868
Total operating expenses	1,012,578	963,918
Income from operations	22,112	19,795
Nonoperating gains and losses:		
Net realized gains (losses) on board-designated investments	2,073	(8,902)
Other nonoperating gains (losses), net	560	(85)
Total nonoperating gains (losses), net	2,633	(8,987)
Excess of revenues over expenses	$ 24,745	$ 10,808

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets (Continued)

Years ended September 30, 2010 and 2009

(In thousands)

	2010	2009
Unrestricted net assets:		
Excess of revenues over expenses	$ 24,745	$ 10,808
Other changes in unrestricted net assets:		
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	(20,017)	(57,439)
Effect of changing pension and postretirement plans' measurement date pursuant to ASC Topic 715	—	(3,935)
Net change in unrealized gains on investments available for sale	9,953	827
Net assets released from restrictions used for purchase of property and equipment	4,766	10,648
Decrease in interest in net assets of Rhode Island Hospital Foundation	(856)	(3,690)
(Decrease) increase in noncontrolling interest in affiliate	(23)	2,616
Increase (decrease) in unrestricted net assets	18,568	(40,165)
Temporarily restricted net assets:		
Gifts, grants and bequests	59,981	57,919
Income from restricted endowment and other restricted investments	2,664	2,170
(Decrease) increase in interest in net assets of Rhode Island Hospital Foundation	(769)	703
Transfers from Rhode Island Hospital Foundation	5,292	6,033
Net assets released from restrictions	(72,223)	(71,487)
Net realized and unrealized gains (losses) on investments	18,920	(5,673)
Reclassification from adoption of UPMIFA (note 3(h))	—	97,284
Increase (decrease) in temporarily restricted net assets	13,865	86,949
Permanently restricted net assets:		
Net change in unrealized gains on investments	585	(340)
Increase (decrease) in interest in net assets of Rhode Island Hospital Foundation	9,830	(4,272)
Reclassification from adoption of UPMIFA (note 3(h))	—	(97,284)
Other decreases	—	(16)
Increase (decrease) in permanently restricted net assets	10,415	(101,912)
Increase (decrease) in net assets	42,848	(55,128)
Net assets, beginning of year	659,058	714,186
Net assets, end of year	$ 701,906	$ 659,058

See accompanying notes to consolidated financial statements.

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Cash Flows

Years ended September 30, 2010 and 2009

(In thousands)

	2010	2009
Cash flows from operating activities:		
Increase (decrease) in net assets	$ 42,848	$ (55,128)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	20,017	57,439
Effect of changing pension and postretirement plans' measurement date pursuant to ASC Topic 715	—	3,935
Net realized and unrealized (gains) losses on investments	(31,531)	14,088
Undistributed portion of change in interest in net assets of Rhode Island Hospital Foundation	(8,205)	7,259
Transfers from Rhode Island Hospital Foundation	(5,292)	(6,033)
Depreciation and amortization	33,727	32,698
Provision for estimated health care benefit self-insurance costs	55,248	59,248
Decrease in liabilities for estimated health care benefit self-insurance costs resulting from claims paid	(55,771)	(58,028)
Net increase in patient accounts receivable	(12,707)	(10,785)
Increase in accounts payable	3,130	501
(Decrease) increase in accrued employee benefits and compensation	(7,162)	11,624
(Decrease) increase in estimated third-party payor settlements	(2,969)	7,816
Increase (decrease) in all other current and noncurrent assets and liabilities, net	4,823	(5,593)
Net cash provided by operating activities	36,156	59,041
Cash flows from investing activities:		
Purchase of property and equipment	(38,449)	(42,314)
Net decrease (increase) in trustee-held bond funds	11,773	(45,852)
Other net (increases) decreases in assets limited as to use	(42,005)	1,612
Net cash used in investing activities	(68,681)	(86,554)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	—	72,441
Payments on long-term debt	(6,851)	(3,371)
Transfers from Rhode Island Hospital Foundation	5,292	6,033
Net cash (used in) provided by financing activities	(1,559)	75,103
Net (decrease) increase in cash and cash equivalents	(34,084)	47,590
Cash and cash equivalents, beginning of year	81,927	34,337
Cash and cash equivalents, end of year	$ 47,843	$ 81,927
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 15,084	$ 10,861

See accompanying notes to consolidated financial statements.

(In thousands)

(1) Description of Organization

Rhode Island Hospital (the Hospital), located in Providence, Rhode Island, is a 719-bed nonprofit general acute care teaching hospital with university affiliation providing a comprehensive range of diagnostic and therapeutic services (excluding obstetrics) for the acute care of patients principally from Rhode Island and southeastern Massachusetts. As a complement to its role in service and education, the Hospital actively supports research. The Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and participates as a provider primarily in Medicare, Blue Cross and Medicaid programs. The Hospital is also a member of Voluntary Hospitals of America, Inc. (VHA).

Effective August 9, 1994, the Hospital and The Miriam Hospital (TMH) of Providence, RI (247 beds) implemented a plan which included the creation of a not-for-profit parent company, Lifespan Corporation. Each hospital continues to maintain its own identity and Board of Trustees, as well as its own campus and its own name. Lifespan, the sole member of the Hospital and TMH, has the responsibility for strategic planning and initiatives, capital and operating budgets, and overall governance of the consolidated organization.

(2) Charity Care and Other Community Benefits

The total net cost of charity care and other community benefits provided by the Hospital for the years ended September 30, 2010 and 2009 is summarized in the following table:

	2010	2009
Charity care	$ 39,626	$ 29,272
Medical education, net	42,425	38,986
Research	9,797	9,414
Subsidized health services	6,900	5,973
Community health improvement services and community benefit operations	984	754
Total	$ 99,732	$ 84,399

Charity Care

The Hospital provides full charity care for individuals at or below twice the federal poverty level, with a sliding scale for individuals up to four times the poverty level. In addition, a substantial charity allowance is offered to all other uninsured patients. The Hospital determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including compensation and benefits, supplies, and other operating expenses, based on data from its costing system. The total cost, excluding medical education and research, incurred by the Hospital to provide charity care amounted to $39,626 and $29,272 in 2010 and 2009, respectively. Charges forgone, based on established rates, amounted to $160,728 and $117,138 in 2010 and 2009, respectively.

(2) Charity Care and Other Community Benefits (continued)

Medical Education

The Hospital provides the setting for and substantially supports medical education in various clinical training and nursing programs. The total cost of medical education provided by the Hospital exceeds the reimbursement received from third-party payors by $42,425 and $38,986 in 2010 and 2009, respectively.

In 1969, the Hospital and certain other Rhode Island hospitals entered into an affiliation agreement to participate jointly in various clinical training programs and research activities with Brown Medical School, renamed The Warren Alpert Medical School of Brown University (Brown). In 2010, Brown named the Hospital its Principal Teaching Hospital. TMH and Emma Pendleton Bradley Hospital (EPBH) continue to be designated as major teaching affiliates. The goals of the partnership are to facilitate the expansion of joint educational and research programs in order to compete both clinically and academically. The Hospital sponsors 44 graduate medical education programs accredited by or under the auspices of the Accreditation Council for Graduate Medical Education (ACGME), while also sponsoring another 26 hospital-approved residency and fellowship programs. The Hospital serves as the principal setting for these clinical training programs, which encompass the following disciplines: internal medicine and medicine subspecialties, including hematology and oncology; orthopedics and orthopedic subspecialties; clinical neurosciences; general surgery and surgical specialties; pediatrics and pediatric specialties, including hematology and oncology; dermatology; radiology; pathology; child psychiatry; emergency medicine; emergency medicine specialties; dentistry; and medical physics. The Hospital provides stipends to residents and physician fellows while in training.

The Hospital is also a participating clinical training site for residents from other programs in anesthesiology, pediatric dentistry, family medicine, infectious disease, obstetrics/gynecology (OB/Gyn) and OB/Gyn subspecialties, otolaryngology, podiatry, psychiatry, geriatric psychiatry, orthopedics, pulmonary medicine, rheumatology, general surgery, colorectal surgery, cardiothoracic surgery, and radiation oncology programs.

With respect to nursing education, the Hospital has developed formal and informal educational affiliations with the University of Rhode Island College of Nursing; Rhode Island College; the Community College of Rhode Island; Salve Regina University; Boston College; Yale University; Regis College; Simmons College; St. Joseph's Health Services' School of Nursing; the University of Massachusetts campuses at Dartmouth, Boston, Amherst and Worcester; the University of Connecticut; New England Technical Institute; and the University of Pennsylvania, pursuant to which their nursing students obtain clinical training and experience at the Hospital. The Hospital does not receive any compensation from the various schools for providing a clinical setting for the student nurse training.

(Continued)

(2) Charity Care and Other Community Benefits (continued)

The Hospital sponsors training programs in the following medical fields: medical technology; diagnostic medical sonography; nuclear medical technology; radiologic technology; mammography; computer tomography; and magnetic resonance imaging. At the Hospital, clinical affiliations/student clinical training programs are provided through contracts with a number of colleges and universities in the professional areas of speech-language pathology and audiology, physical therapy, and occupational therapy. In addition, the Hospital serves as the clinical setting for training programs in histology, phlebotomy, child development and social work.

The Hospital has clinical affiliations/student clinical training programs for pharmacy students provided through contracts with a number of colleges and universities.

Research

The Hospital conducts extensive medical research and is in the forefront of biomedical health care delivery research and among the leaders nationally in National Institutes of Health programs. The Hospital also sponsors a significant level of these research activities, as indicated in the table on page 6.

Federal support accounts for approximately 78% of all externally funded research at the Hospital. Researchers focus on clinical trials which investigate prevention and treatment of HIV/AIDS, obesity, cancer, diabetes, cardiac disease, neurological problems, and mental health concerns. Researchers may work in the laboratory or with patients, or both.

Subsidized Health Services

The Hospital substantially subsidizes various health services including the following clinics: surgical, diabetes, resident/fellowships specialty training, dental, adolescent and Alzheimer's, as well as the Center for Special Children and early intervention.

Community Health Improvement Services and Community Benefit Operations

The Hospital also provides numerous other services to the community for which charges are not generated. These services include certain emergency services, community health screenings for cardiac health, prostate cancer and other diseases, smoking cessation and weight loss programs, diabetes education, patient advocacy, foreign language translation, physician referral services and charitable contributions.

(3) Summary of Significant Accounting Policies

(a) Basis of Presentation

The consolidated financial statements also include the accounts of RIH Ventures (RIHV), Hospital Properties, Inc. (HPI) and Radiosurgery Center of Rhode Island, LLC (RCRI). Operations of RIHV include phlebotomy services which facilitate laboratory specimen testing, as well as parking facilities that serve patients and staff of the Hospital. HPI owns and operates a physicians' office building on behalf of the Hospital. RIH owns a 55% interest in RCRI, a limited liability company formed to operate a radiation therapy center utilizing cyberknife technology. All significant intercompany accounts and transactions have been eliminated in consolidation.

(Continued)

(3) Summary of Significant Accounting Policies (continued)

Following is a description of the valuation methodologies used for investments measured at fair value:

Cash and short-term investments: Valued at the net asset value (NAV) reported by the financial institution.

U.S. government/agency and corporate obligations: Valued using market quotations or prices obtained from independent pricing sources which may employ various pricing methods to value the investments.

Corporate equity securities: Valued at the closing price reported by an active market in which the individual securities are traded.

Collective investment funds: Valued using NAV as reported by the investment manager, which approximates the market values of the underlying investments within the fund or realizable value as estimated by the investment manager.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated statements of financial position. Investments in collective investment funds with monthly pricing and liquidity are measured based on the fair value of the underlying investments; otherwise, such investments are recorded at historical cost. Investments of less than 5% in limited partnerships are also recorded at historical cost. Investments of 5% or more in limited partnerships, limited liability corporations or similar investments are accounted for using the equity method. Investments in derivative financial instruments are not material.

The Hospital has applied the accounting guidance in Accounting Standards Update No. 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)* (ASU 2009-12), which permits the use of NAV or its equivalent reported by each underlying alternative investment fund as a practical expedient to estimate the fair value of the investment. These investments are generally redeemable or may be liquidated at NAV under the original terms of the subscription agreements or operations of the underlying funds. However, it is possible that these redemption rights may be restricted by the funds in the future in accordance with the underlying fund agreements, as applicable. Changes in market conditions, the economic environment, or the funds' liquidity provisions may significantly impact the NAV of the funds and, consequently, the fair value of the Hospital's interests in the funds. Although certain investments may be sold in a secondary market, the secondary market is not active and individual transactions are not necessarily observable. It is therefore reasonably possible that if the Hospital were to sell a fund in the secondary market, the sale could occur at an amount materially different than the reported value.

Investments designated by the Hospital as trading assets are reported at fair value, with gains or losses resulting from changes in fair value recognized in the consolidated statement of operations and changes in net assets as realized gains or losses on investments.

(Continued)

(3) Summary of Significant Accounting Policies (continued)

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments other than those designated as trading assets or those accounted for using the equity method are excluded from the excess of revenues over expenses.

Realized gains or losses on sales of investments are determined by the average cost method. Realized gains or losses on unrestricted investments are recorded as nonoperating gains or losses; realized gains or losses on restricted investments are recorded as an addition to or deduction from the appropriate restricted net assets. For investment securities other than trading, a decline in the market value of the security below its cost that is designated to be other than temporary is recognized through an impairment charge classified as a realized loss and a new cost basis is established.

Investment income from funds held by trustees under bond indenture agreements is recorded as other revenue. The Hospital maintains a spending policy for certain of its board-designated funds which provides that investment income from such funds is recorded within unrestricted revenues as endowment earnings contributed toward community benefit.

Income from permanently restricted investments is recorded as nonoperating gains when unrestricted by donor and as an addition to the net assets of the appropriate temporarily restricted fund when restricted by donor.

(e) Assets Limited as to Use

Assets limited as to use primarily include designated assets set aside by the Hospital's Board for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes, and assets whose use by the Hospital has been permanently restricted by donors or limited by grantors or donors to a specific purpose, as well as assets held by trustees under bond indenture agreements and irrevocable split-interest trusts. Amounts required to meet current liabilities of the Hospital are reported in current assets in the consolidated statements of financial position.

(f) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is computed over the estimated useful life of each class of depreciable asset using the straight-line method. Buildings and improvements lives range from 5 to 40 years and equipment from 3 to 20 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

(g) Deferred Financing Costs

Deferred financing costs, which relate to the issuance of long-term bonds payable to the Rhode Island Health and Educational Building Corporation (RIHEBC), are being amortized ratably over the periods the bonds are outstanding.

(Continued)

(3) Summary of Significant Accounting Policies (continued)

(h) Classification of Net Assets

FASB ASC Subtopic 958-250 (ASC 958-250) provides guidance on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that is subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA) and also requires disclosures about endowment funds, including donor-restricted endowment funds and board-designated endowment funds.

The Hospital is incorporated in and subject to the laws of Rhode Island, which adopted UPMIFA effective as of June 30, 2009. Under UPMIFA, the assets of a donor-restricted endowment fund may be appropriated for expenditure by the Hospital in accordance with the standard of prudence prescribed by UPMIFA. As a result of this new law and the adoption of ASC 958-250, the Hospital has classified its net assets as follows:

- *Permanently restricted net assets* contain donor-imposed stipulations that neither expire with the passage of time nor can be fulfilled or otherwise removed by actions of the Hospital and primarily consist of the historic dollar value of contributions to establish or add to donor-restricted endowment funds.
- *Temporarily restricted net assets* contain grantor or donor-imposed stipulations as to the timing of their availability or use for a particular purpose, including research activities. These net assets are released from restrictions when the specified time elapses or when actions have been taken to meet the restrictions. Net assets of donor-restricted endowment funds in excess of their historic dollar value are classified as temporarily restricted net assets until appropriated by the Hospital and spent in accordance with the standard of prudence imposed by UPMIFA.
- *Unrestricted net assets* contain no donor-imposed restrictions and are available for the general operations of the Hospital. Such net assets may be designated by the Hospital for specific purposes, including to function as endowment funds.

Prior to 2009, the Hospital was subject to the Rhode Island Uniform Management of Institutional Funds Act (UMIFA), as amended. Rhode Island's enacted version of UMIFA required the Hospital to maintain the purchasing power of the historic dollar value of its donor-restricted endowment funds and, as a result, the Hospital annually added a portion of the funds' return to permanently restricted net assets to account for inflation. This requirement was eliminated by the enactment of UPMIFA and accordingly, in 2009 the Hospital reclassified the $97,284 cumulative amount of such additions from permanently restricted net assets to temporarily restricted net assets. See note 5 for more information about the Hospital's endowment.

(i) Excess of Revenues Over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include the change in the funded status of pension and

(3) Summary of Significant Accounting Policies (continued)

other postretirement plans, the effect of changing pension and other postretirement plans' measurement date pursuant to ASC Topic 715, the net change in unrealized gains and losses on investments available for sale, net assets released from restrictions used for purchase of property and equipment, the change in interest in net assets of Rhode Island Hospital Foundation, and the change in noncontrolling interest in affiliate.

(j) Net Patient Service Revenue

The Hospital provides care to patients under Medicare, Medicaid, managed care and commercial insurance contractual arrangements. The Hospital has agreements with many third-party payors that provide for payments to the Hospital at amounts less than its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with some third-party payors.

Medicare and Medicaid utilize prospective payment systems for most inpatient hospital services rendered to program beneficiaries based on the classification of each case into a diagnostic-related group (DRG). Outpatient hospital services are primarily paid using an ambulatory payment classification system.

The majority of payments from managed care and commercial insurance companies are based upon negotiated fixed fee arrangements, whereby a combination of per diem rates and specific case rates are utilized for inpatient services, along with fixed fees applicable to outpatient services.

Settlements and adjustments arising under reimbursement arrangements with some third-party payors, primarily Medicare, Medicaid, and Blue Cross, are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Hospital has classified a portion of accrued estimated third-party payor settlements as long-term because such amounts, by their nature or by virtue of regulation or legislation, will not be paid within one year. Changes in the Medicare and Medicaid programs, such as the reduction of reimbursement, could have an adverse impact on the Hospital.

(k) Provision for Bad Debts

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

(3) Summary of Significant Accounting Policies (continued)

(l) Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. The gifts are reported as temporarily or permanently restricted support that increase those net asset classes if they are received with stipulations that limit the use of the assets. When a donor or grantor restriction expires, that is, when a stipulated purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

(n) Inventories

Inventories, consisting primarily of medical/surgical supplies and pharmaceuticals, are stated at the lower of cost or market.

(o) Estimated Self-Insurance Costs

The Hospital participates in Lifespan self-insurance programs with other Lifespan affiliates for losses arising from medical malpractice and general liability claims, health benefits to its employees, and losses arising from workers' compensation claims. The Hospital has recorded provisions for estimated claims, which are based on Lifespan's own experience. The provisions for self-insured losses include estimates of the ultimate costs for both reported claims and claims incurred but not reported.

(p) Fair Value of Financial Instruments

The carrying amounts recorded in the consolidated statements of financial position for cash and cash equivalents, patient accounts receivable, assets limited as to use, accounts payable, accrued expenses, estimated third-party payor settlements, and estimated health care benefit self-insurance costs approximate their respective fair values. The estimated fair values of the Hospital's assets limited as to use and long-term debt are disclosed in notes 5, 8 and 11, respectively.

(q) Reclassifications

Certain 2009 amounts have been reclassified to conform with the 2010 reporting format.

(In thousands)

(4) Disproportionate Share

The Hospital is a participant in the State of Rhode Island's Disproportionate Share Program, established in 1995 to assist hospitals which provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the Hospital, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. Total payments to the Hospital under the Disproportionate Share Program aggregated $47,896 and $44,326 in 2010 and 2009, respectively, and are reflected as part of net patient service revenue in the accompanying consolidated statements of operations and changes in net assets.

In 2010 and 2009, the State of Rhode Island has assessed a license fee to all Rhode Island hospitals, based on each hospital's 2008 and 2007 net patient service revenue, respectively, as defined. The Hospital's license fee expense was $41,233 in 2010 and $40,868 in 2009. The hospitals in the State of Rhode Island accepted the fee as part of an agreement with the State's Department of Health and Human Services in return for an equitable distribution of funds to those hospitals meeting certain criteria in providing services to the Medicaid population.

For periods beyond 2010, the federal government could change the level of federal matching funds for the Disproportionate Share Program. Accordingly, it may be necessary for the State of Rhode Island to modify the program and the reimbursement to Rhode Island hospitals under the program. At this time, the scope of such modifications or their effect on the Hospital cannot be reasonably determined.

(5) Investments

The composition of assets limited as to use at September 30, 2010 and 2009 is set forth in the following table:

	2010	2009
Unrestricted board-designated funds	$ 231,998	$ 174,921
Held by trustee under bond indenture agreements	35,315	47,088
Temporarily restricted funds	205,125	189,041
Permanently restricted funds	38,489	38,114
Total	$ 510,927	$ 449,164

(Continued)

(In thousands)

(5) Investments (continued)

Assets limited as to use at September 30 are classified as follows:

	2010	2009
Available-for-sale	$ 389,710	$ 305,966
Trading	121,217	143,198
Total	$ 510,927	$ 449,164

Fair Value

The following table summarizes the Hospital's investments and assets held in trust by major category within the ASC 820-10 fair value hierarchy as of September 30, 2010 and 2009, as well as related strategy and liquidity/notice requirements:

	2010				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
U.S. equities:						
Large cap value	$ 15,224	$ —	$ —	$ 15,224	Daily	One
Mid-cap value	15,707	—	—	15,707	Daily	One
Large cap growth	16,583	—	—	16,583	Daily	One
Marketable alternatives:						
Multiple strategies	—	52,829	—	52,829	Quarterly	Sixty-five
Absolute return strategies	—	22,680	—	22,680	Monthly	Five
International equities:						
Developed markets	—	57,674	—	57,674	Daily - Monthly	One - Seven
Emerging markets	—	16,214	—	16,214	Monthly	Ten
Commodities:						
Energy	10,463	—	—	10,463	Daily	One
Various	—	7,577	—	7,577	Monthly	Eight
Real estate	9,004	—	—	9,004	Daily	Five
Fixed income:						
U.S. Treasuries	14,455	—	—	14,455	Daily	One - Five
U.S. Treasury inflation-protected	—	35,341	—	35,341	Daily	Two
U.S. Government and agency	—	6,478	—	6,478	Daily	One
Domestic bonds	36,606	18,693	—	55,299	Daily	One
Global bonds	16,023	29,744	236	46,003	Daily - Illiquid	One - N/A
Cash and short-term investments	27,296	—	—	27,296	Daily	One
	161,361	247,230	236	408,827		
Assets held in trust (note 6)	—	—	11,860	11,860		
Held by trustee under bond indenture agreements (note 11)	35,315	—	—	35,315		
Total	$ 196,676	$ 247,230	$ 12,096	$ 456,002		

(Continued)

(In thousands)

(5) Investments (continued)

	2009				Redemption or liquidation	Days' notice
	Level 1	Level 2	Level 3	Total		
U.S. equities:						
Large cap value	$ 12,703	$ —	$ —	$ 12,703	Daily	One
Mid-cap value	5,267	—	—	5,267	Daily	One
Large cap growth	15,036	—	—	15,036	Daily	One
Marketable alternatives:						
Multiple strategies	—	48,170	—	48,170	Quarterly	Forty-five
Absolute return strategies	—	16,825	—	16,825	Monthly	Five
International equities:						
Developed markets	—	38,582	—	38,582	Daily - Monthly	One - Seven
Emerging markets	9,566	—	—	9,566	Daily	One
Commodities:						
Energy	1,873	—	—	1,873	Daily	One
Various	14,838	5,800	—	20,638	Daily - Monthly	One - Eight
Real estate	7,457	—	—	7,457	Daily	Five
Fixed income:						
U.S. Treasuries	20,361	—	—	20,361	Daily	One - Five
U.S. Treasury inflation-protected	—	49,588	—	49,588	Daily	Two
U.S. Government and agency	—	11,117	—	11,117	Daily	One - Three
Domestic bonds	—	28,674	—	28,674	Daily	One - Three
Global bonds	28,520	22,463	—	50,983	Daily - Monthly	One - Thirty
Casn and short-term investments	1,702	—	—	1,702	Daily	One
	117,323	221,219	—	338,542		
Assets held in trust (note 6)	—	—	11,275	11,275		
Held by trustee under bond indenture agreements (note 11)	40,596	6,492	—	47,088		
Total	$ 157,919	$ 227,711	$ 11,275	$ 396,905		

Trustee-held investments under bond indenture agreements consist of cash equivalents as well as U.S. Treasury and agency securities.

Investments in collective investment funds which do not have monthly pricing or liquidity are recorded at historical cost. Investments of less than 5% in limited partnerships are also recorded at historical cost. The aggregate historical cost of these investments, which approximates market value as reported by investment managers, amounted to $54,925 at September 30, 2010 and $52,259 at September 30, 2009.

Most investments classified in Levels 2 and 3 consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings, which may be marketable. Because the NAV reported by each fund is used as a practical expedient to estimate the fair value of the Hospital's interest therein, its classification in Level 2 or 3 is based on the Hospital's ability to redeem its interest at or near the date of the consolidated statement of financial position. If the interest can be redeemed in the near term, the investment is generally classified in Level 2. The classification of investments in the fair value hierarchy is not necessarily an indication of the risks, liquidity, or degree of difficulty in estimating the fair value of each investment's underlying assets and liabilities.

(Continued)

(In thousands)

(5) Investments (continued)

The following table presents the Hospital's activity for the years ended September 30, 2010 and 2009 for investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in ASC 820-10:

	2010			2009
	Global bonds	Assets held in trust	Total	Assets held in trust
Fair value at October 1	$ —	$ 11,275	$ 11,275	$ 11,615
Transfers in	236	—	236	—
Net realized and unrealized gains (losses)	—	585	585	(340)
Fair value at September 30	$ 236	$ 11,860	$ 12,096	$ 11,275

Investment Income, Gains and Losses

Investment income, gains and losses for cash equivalents and assets limited as to use are comprised of the following for the years ended September 30:

	2010	2009
Other revenue:		
Investment income	$ 307	$ 146
Endowment earnings contributed toward community benefit:		
Dividend and interest income	$ 7,822	$ 6,570
Nonoperating gains and losses:		
Net realized gains (losses) on board-designated investments	$ 2,073	$ (8,902)
Other changes in unrestricted net assets:		
Net change in unrealized gains on investments available for sale	$ 9,953	$ 827
Changes in temporarily restricted net assets:		
Income from restricted endowment and other restricted investments	$ 2,664	$ 2,170
Net realized and unrealized gains (losses) on investments	18,920	(5,673)
	$ 21,584	$ (3,503)
Changes in permanently restricted net assets:		
Net change in unrealized gains on investments	$ 585	$ (340)

(Continued)

(In thousands)

(5) Investments (continued)

Liquidity

Investments as of September 30, 2010 and 2009 are summarized below based on when they may be redeemed or sold:

	2010	2009
Investment redemption or sale period:		
Daily	$ 293,039	$ 265,071
Monthly	89,664	64,832
Quarterly	52,828	47,958
One-to-five years	1,122	391
Locked-up until liquidation	19,349	18,653
Total	$ 456,002	$ 396,905

Locked-up until liquidation includes assets held in trust (note 6) and trustee-held debt service reserve funds under bond indenture agreements (note 11).

Commitments

Venture capital, private equity, and certain energy and real estate investments are made through limited partnerships. Under the terms of these agreements, the Hospital is obligated to remit additional funding periodically as capital or liquidity calls are exercised by the manager. These partnerships have a limited existence, generally ten years, and such agreements may provide for annual extensions for the purpose of disposing portfolio positions and returning capital to investors. However, depending on market conditions, the inability to execute the fund's strategy, and other factors, a manager may extend the terms of a fund beyond its originally anticipated existence or may wind the fund down prematurely. The Hospital cannot anticipate such changes because they are based on unforeseen events, but should they occur they may result in less liquidity or return from the investment than originally anticipated. As a result, the timing and amount of future capital or liquidity calls expected to be exercised in any particular future year is uncertain. The aggregate amount of unfunded commitments associated with the above noted investment categories as of September 30, 2010 was $3,810.

(Continued)

(In thousands)

(5) Investments (continued)

Investments with Unrealized Losses

Information regarding investments with unrealized losses at September 30, 2010 and 2009 is presented below, segregated between those that have been in a continuous unrealized loss position for less than twelve months and those that have been in a continuous unrealized loss position for twelve or more months:

	Less than 12 months		12 months or longer		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
September 30, 2010:						
Unrestricted board-designated and temporarily restricted funds:						
Collective investment funds	$ —	$ —	$ 23,618	$ 563	$ 23,618	$ 563
Total temporarily impaired securities	$ —	$ —	$ 23,618	$ 563	$ 23,618	$ 563

	Less than 12 months		12 months or longer		Total	
	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
September 30, 2009:						
Unrestricted board-designated and temporarily restricted funds:						
Collective investment funds	$ —	$ —	$ 27,938	$ 5,038	$ 27,938	$ 5,038
Total temporarily impaired securities	$ —	$ —	$ 27,938	$ 5,038	$ 27,938	$ 5,038

In the evaluation of whether an impairment is other than temporary, the Hospital considers the reasons for the impairment, its ability and intent to hold the investment until the market price recovers, the severity and duration of the impairment, and expected future performance. Based on this evaluation, no impairment was considered to be other than temporary.

Securities Lending

The Hospital participates in a securities lending program in which it lends a portion of its investments to pre-approved third party borrowers that meet certain criteria through a lending agent. All securities on loan are fully collateralized by cash or debt instruments in amounts greater than the market value of the securities on loan. The lending agent is responsible for ensuring the creditworthiness of the borrowers and investing collateral assets in high quality securities. These investments consist primarily of U.S. dollar-denominated fixed income adjustable rate securities and U.S. government securities with short maturities.

(Continued)

(In thousands)

(5) Investments (continued)

Endowments

The Hospital's endowment consists of approximately 304 individual funds established for a variety of purposes, including both donor-restricted endowment funds and funds designated by the Hospital to function as endowments. Investments associated with endowment funds, including funds designated by the Hospital to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Endowment funds consist of the following at September 30, 2010:

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	$ 205,125	$ 38,489	$ 243,614
Internally board-designated endowment funds	231,998	—	—	231,998
Total endowment funds	$ 231,998	$ 205,125	$ 38,489	$ 475,612

Endowment funds consist of the following at September 30, 2009:

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Donor-restricted endowment funds	$ —	$ 189,041	$ 38,114	$ 227,155
Internally board-designated endowment funds	174,921	—	—	174,921
Total endowment funds	$ 174,921	$ 189,041	$ 38,114	$ 402,076

(Continued)

(In thousands)

Endowments (continued)

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

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment funds, October 1, 2009	$ 174,921	$ 189,041	$ 38,114	$ 402,076
Interest and dividend income	7,859	2,664		10,523
Net realized and unrealized gains	12,026	18,920	585	31,531
Cash gifts, grants and bequests	—	61,431	—	61,431
Transfers from Rhode Island Hospital Foundation	—	5,292	—	5,292
Net assets released from restrictions	—	(72,223)	—	(72,223)
Deposits	39,342	—	—	39,342
Withdrawals	(2,150)	—	—	(2,150)
Other decreases	—	—	(210)	(210)
Endowment funds, September 30, 2010	$ 231,998	$ 205,125	$ 38,489	$ 475,612

(Continued)

(In thousands)

Endowments (continued)

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

	Unrestricted board-designated	Temporarily restricted	Permanently restricted	Total
Endowment funds, October 1, 2008	$ 177,138	$ 104,956	$ 135,682	$ 417,776
Reclassification from adoption of UPMIFA	—	97,284	(97,284)	—
Interest and dividend income	6,600	2,170	—	8,770
Net realized and unrealized losses	(8,075)	(5,673)	(340)	(14,088)
Cash gifts, grants and bequests	—	55,758	—	55,758
Transfers from Rhode Island Hospital Foundation	—	6,033	—	6,033
Net assets released from restrictions	—	(71,487)	—	(71,487)
Deposits	921	—	—	921
Withdrawals	(1,663)	—	—	(1,663)
Other increases	—	—	56	56
Endowment funds, September 30, 2009	$ 174,921	$ 189,041	$ 38,114	$ 402,076

(a) Interpretation of Relevant Law

The portion of donor-restricted endowment funds that is not classified as permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, the Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- The duration and preservation of the fund
- The purposes of the Hospital and donor-restricted endowment funds
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the Hospital
- The investment policies of Lifespan

(Continued)

Endowments (continued)

(b) Return Objectives and Risk Parameters

Lifespan has adopted investment policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets, including both donor-restricted funds and unrestricted board-designated funds. Under this policy, as approved by Lifespan, the endowment assets are invested in a manner that is intended to produce results that exceed the total benchmark return while assuming a moderate level of investment risk. The Hospital expects its endowment funds, over a full market cycle, to provide an average annual real rate of return of approximately 5.0% plus inflation annually. Actual returns in any given year or period of years may vary from this amount.

(c) Strategies Employed for Achieving Objectives

To satisfy its long-term rate of return objectives, Lifespan relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). Lifespan targets a diversified asset allocation that places emphasis on investments in public equity, marketable alternatives, real assets and fixed income to achieve its long-term return objectives within prudent risk constraints.

(d) Spending Policy

The Hospital invests its endowment funds in accordance with the total return concept. Applicable endowments include unrestricted board-designated endowment funds and donor-restricted endowment funds. The governing board of the Hospital has approved an endowment spending rate of 4% based on all of the above factors. This spending rate is applied to the average fair value of the applicable endowments for the immediately preceding three years.

(6) Assets Held in Trust

The Hospital is a beneficiary of various irrevocable split-interest trusts. The fair market value of these investments at September 30, 2010 and 2009 was approximately $11,860 and $11,275, respectively, and is reported as permanently restricted funds within assets limited as to use in the consolidated statements of financial position.

(Continued)

(In thousands)

(7) Property and Equipment

Property and equipment, by major category, is as follows at September 30:

	2010	2009
Land and improvements	$ 23,736	$ 23,695
Buildings and improvements	647,316	630,749
Equipment	321,587	311,487
	992,639	965,931
Less accumulated depreciation and amortization	524,585	500,981
	468,054	464,950
Construction in progress	26,530	24,345
Property and equipment, net	$ 494,584	$ 489,295

Depreciation and amortization expense for the years ended September 30, 2010 and 2009 amounted to $33,727 and $32,698, respectively.

The estimated cost of completion of construction in progress approximated $3,000 at September 30, 2010, comprised mainly of various building renovation projects. In addition, the Hospital has several building renovation projects pending contractual commitments with an estimated cost of completion of approximately $13,000.

It is the Hospital's policy to capitalize the net amount of interest cost associated with significant capital additions as a component of the cost of such assets, which is amortized over the asset's estimated useful life. No interest was capitalized in 2010 and 2009.

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits

Change in Measurement Date of Pension and Other Postretirement Benefit Plans

Beginning in fiscal 2009, FASB ASC Topic 715, *Compensation-Retirement Benefits: Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans* (ASC 715), requires Lifespan to measure the funded status of its benefit plans as of September 30. Lifespan formerly used a measurement date of June 30 for its benefit plans. Implementation of this change reduced Lifespan's unrestricted net assets by $5,957, comprised of the following effects from July 1, 2008 through September 30, 2008:

	Lifespan Corporation Retirement Plan	Lifespan Corporation Postretirement Benefit Plan	Total
Service cost	$ 5,559	$ 122	$ 5,681
Interest cost	5,442	397	5,839
Expected return on plan assets	(5,706)	—	(5,706)
Amortization of net actuarial loss	77	106	183
Amortization of prior service cost (benefit)	224	(264)	(40)
Total reduction to unrestricted net assets of Lifespan	$ 5,596	$ 361	$ 5,957
Total reduction to unrestricted net assets of the Hospital	$ 3,539	$ 396	$ 3,935

Pension Benefits

Lifespan Corp. sponsors the Lifespan Corporation Retirement Plan (the Plan), which was established effective January 1, 1996 when the Rhode Island Hospital Retirement Plan (the RIH Plan) merged into The Miriam Hospital Retirement Plan. Upon completion of the merger, the new plan was renamed and is governed by provisions of the Lifespan Corporation Retirement Plan. Each employee who was a participant in the RIH Plan and was an eligible employee on January 1, 1996 continues to be a participant on and after January 1, 1996, subject to the provisions of the Plan. Employees are included in the Plan on the first of the month which is the later of their first anniversary of employment or the attainment of age 18.

The Plan is intended to constitute a plan described in Section 414(k) of the Internal Revenue Code, under which benefits are derived from employer contributions based on the separate account balances of participants in addition to the defined benefits provided under the Plan, which are based on an employee's years of credited service and annual compensation. Lifespan's funding policy is to contribute amounts to the Plan sufficient to meet minimum funding requirements set forth in the Employee Retirement Income

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

Security Act of 1974 (ERISA) and the Internal Revenue Code as amended, plus such additional amounts as may be determined to be appropriate by Lifespan.

Substantially all employees of Lifespan Corporation who meet the above requirements are eligible to participate in the Plan.

The provisions of ASC 715 require an employer to recognize in its statement of financial position an asset for a benefit plan's overfunded status or a liability for a plan's underfunded status, and to recognize changes in that funded status in the year in which the changes occur through changes in unrestricted net assets. The funded-status amount is measured as the difference between the fair value of plan assets and the projected benefit obligation including all actuarial gains and losses and prior service cost. Based on September 30, 2010 funded-status amounts for the Hospital's portion of the Plan, the Hospital recorded a decrease in unrestricted net assets of $19,220.

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension cost in 2011 are as follows:

Net actuarial loss	$	6,949
Prior service cost		164
	$	7,113

The following tables set forth the Plan's projected benefit obligation and the fair value of plan assets.

	2010	2009
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	$ 452,976	$ 389,966
Service cost	26,012	22,237
Interest cost	27,178	21,769
Plan amendments	157	—
Actuarial loss	39,808	26,505
Benefits paid	(16,715)	(13,858)
Administrative expenses	(1,097)	(928)
Effects of changing the Plan's measurement date:		
Service cost and interest cost for July 1 – September 30, 2008	—	11,001
Benefits paid for July 1 – September 30, 2008	—	(3,716)
Projected benefit obligation at end of year	$ 528,319	$ 452,976

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

The accumulated benefit obligation at the end of 2010 and 2009 was $455,687 and $387,586, respectively.

	2010	2009
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 307,775	$ 351,770
Actual return on plan assets	24,260	(47,725)
Employer contributions	23,803	22,554
Benefits paid	(16,715)	(13,858)
Administrative expenses	(1,097)	(928)
Effects of changing the Plan's measurement date:		
Benefits paid for July 1 – September 30, 2008	—	(3,716)
Administrative expenses paid for July 1 – September 30, 2008	—	(322)
Fair value of plan assets at end of year	$ 338,026	$ 307,775

The funded status of the Plan and amounts recognized in Lifespan's consolidated statements of financial position at September 30, pursuant to ASC Topic 715 (as opposed to ERISA), are as follows:

	2010	2009
Funded status, end of year:		
Fair value of plan assets	$ 338,026	$ 307,775
Projected benefit obligation	528,319	452,976
	$ (190,293)	$ (145,201)

Amounts recognized in the Hospital's consolidated statements of financial position at September 30, 2010 and 2009 are as follows:

	2010	2009
Accrued pension liability	$ 125,337	$ 97,513

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

	2010	2009
Amounts not yet reflected in net periodic pension cost and included in unrestricted net assets:		
Prior service cost	$ (1,834)	$ (2,477)
Accumulated net actuarial loss	(136,545)	(105,607)
Amounts not yet recognized as a component of net periodic pension cost	(138,379)	(108,084)
Accumulated net periodic pension cost in excess of employer contributions	(51,914)	(37,117)
Net amount recognized	$ (190,293)	$ (145,201)

	2010	2009
Sources of change in unrestricted net assets:		
Net loss arising during the year	$ (24,248)	$ (60,270)
New prior service cost	(15)	—
Amortizations:		
Net actuarial loss	672	443
Prior service cost	4,371	873
Total unrestricted net asset loss recognized during the year	$ (19,220)	$ (58,954)

Net Periodic Pension Cost

Components of net periodic pension cost are as follows for the years ended September 30:

	2010	2009
Service cost	$ 26,012	$ 22,237
Interest cost	27,178	21,769
Expected return on plan assets	(23,331)	(22,861)
Amortization of net actuarial loss	7,940	208
Amortization of prior service cost	801	997
Net periodic pension cost for Lifespan	$ 38,600	$ 22,350
Net periodic pension cost for the Hospital	$ 22,628	$ 13,804

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

The following weighted average assumptions were used by the Plan's actuary to determine net periodic pension cost and benefit obligations:

	2010	2009
Discount rate for benefit obligations	4.98%	5.74%
Discount rate for net periodic pension cost	5.74	6.92
Rate of compensation increase	4.50	4.50
Expected long-term rate of return on Plan assets	7.75	8.00

The asset allocation for the Plan at September 30, 2010 and 2009, and the target allocation for 2011, by asset category, are as follows:

Asset category	Target allocation 2011	Percentage of plan assets September 30 2010	2009
U.S. equity	15 - 35%	11.8%	13.6%
Absolute return	0 - 25%	14.3	18.4
International equity	10 - 35%	15.0	19.0
Venture capital	0 - 10%	1.5	1.7
Commodities	0 - 20%	8.2	6.9
Real estate	0 - 15%	2.7	4.8
Fixed income	10 - 50%	45.4	33.5
Cash and cash equivalents	0 - 10%	1.1	2.1
Total		100.0%	100.0%

The above table does not include $75,626 and $63,508 of Plan assets at September 30, 2010 and 2009, respectively, attributable to the separate savings account balances of participants which are managed in various mutual funds by Fidelity Investments (Fidelity).

The overall financial objective of the Plan is to meet present and future obligations to beneficiaries, while minimizing long-term contributions to the Plan (by earning an adequate, risk adjusted return on Plan assets), with moderate volatility in year-to-year contribution levels.

The primary investment objective of the Plan is to attain the expected long-term rate of return on Plan assets in support of the above objective. The Plan's specific investment objective is to attain an average annual real total return (net of investment management fees) of at least 4.75% over the long term (rolling five-year periods). Real total return is the sum of capital appreciation (or loss) and current income (dividends and interest) adjusted for inflation by the Consumer Price Index.

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

Lifespan employs a rigorous process to annually determine the expected long-term rate of return on Plan assets which is only changed based on significant shifts in economic and financial market conditions. These estimates are primarily driven by actual historical asset-class returns along with our long-term outlook for a globally diversified portfolio. Asset allocations are regularly updated based on evaluations of future market returns for each asset class.

Fair Value

The following table summarizes the Plan's investments by major category within the ASC 820-10 fair value hierarchy as of September 30, 2010 and 2009:

	2010				Redemption	Days'
	Level 1	Level 2	Level 3	Total	or liquidation	notice
U.S. equities:						
Large cap value	$ 10,897	$ —	$ —	$ 10,897	Daily	One
Mid-cap value	7,874	—	—	7,874	Daily	One
Large cap growth	11,163	—	—	11,163	Daily	One
Marketable alternatives:						
Multiple strategies	—	26,408	4,062	30,470	Quarterly - Illiquid	Sixty - Ninety
Absolute return strategies	—	7,063	—	7,063	Monthly	Five
International equities:						
Developed markets	—	27,619	—	27,619	Daily - Monthly	One - Seven
Emerging markets	—	11,700	—	11,700	Monthly	Ten
Venture capital	—	—	11,480	11,480	Illiquid	N/A
Commodities:						
Energy	—	6,617	—	6,617	Daily	One
Various	—	10,906	—	10,906	Monthly	Eight
Real estate	3,432	—	—	3,432	Daily	Five
Fixed income:						
U.S. Treasuries	10,259	—	—	10,259	Daily	One
U.S. Treasury inflation-protected	—	14,000	—	14,000	Daily	Two
U.S. Government and agency	—	9,554	—	9,554	Daily	One
Domestic bonds	20,833	36,099	—	56,932	Daily	One
Global bonds	—	27,048	—	27,048	Daily	Fifteen
Cash and cash equivalents	5,386	—	—	5,386	Daily	One
Fidelity mutual funds	75,626	—	—	75,626	Daily	One
Total	$ 145,470	$ 177,014	$ 15,542	$ 338,026		

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

	2009				Redemption	Days'
	Level 1	Level 2	Level 3	Total	or liquidation	notice
U.S. equities:						
Large cap value	$ 11,051	$ —	$ —	$ 11,051	Daily	One
Mid-cap value	7,124	—	—	7,124	Daily	One
Large cap growth	14,415	—	—	14,415	Daily	One
Marketable alternatives:						
Multiple strategies	—	31,452	7,846	39,298	Quarterly - Illiquid	Sixty - Ninety
Absolute return strategies	—	5,650	—	5,650	Monthly	Five
International equities:						
Developed markets	—	34,637	—	34,637	Daily - Monthly	One - Seven
Emerging markets	9,787	2,145	—	11,932	Daily	One - Five
Venture capital	—	—	12,509	12,509	Illiquid	N/A
Commodities:						
Energy	—	3,074	—	3,074	Daily	One
Various	—	9,108	—	9,108	Monthly	Eight
Real estate	7,671	—	—	7,671	Daily	Five
Fixed income:						
U.S. Treasuries	3,383	—	—	3,383	Daily	One
U.S. Treasury inflation-protected	—	30,168	—	30,168	Daily	Two
U.S. Government and agency	—	7,025	—	7,025	Daily	One
Domestic bonds	—	13,321	—	13,321	Daily	One - Three
Global bonds	—	25,457	—	25,457	Daily	Fifteen
Cash and cash equivalents	8,444	—	—	8,444	Daily	One
Fidelity mutual funds	63,508	—	—	63,508	Daily	One
Total	$ 125,383	$ 162,037	$ 20,355	$ 307,775		

The following table sets forth a summary of changes in the fair value of the Plan's Level 3 investments for the years ended September 30, 2010 and 2009:

	Venture capital	Marketable alternatives	2010 Total
Fair value at October 1, 2009	$ 12,509	$ 7,846	$ 20,355
Net purchases (sales)	(1,583)	4,050	2,467
Transfers out	—	(7,846)	(7,846)
Realized gains, net	1,148	—	1,148
Unrealized (losses) gains, net	(594)	12	(582)
Fair value at September 30, 2010	$ 11,480	$ 4,062	$ 15,542

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

	Venture capital	Marketable alternatives	2009 Total
Fair value at October 1, 2008	$ 14,486	$ 8,381	$ 22,867
Net sales	(160)	—	(160)
Transfers out	—	(939)	(939)
Realized gains, net	454	—	454
Unrealized (losses) gains, net	(2,271)	404	(1,867)
Fair value at September 30, 2009	$ 12,509	$ 7,846	$ 20,355

Expected Cash Flows

Information about the expected cash flows for the Plan is as follows:

Employer contributions:	
2011 (expected for Lifespan)	$ 43,939
2011 (expected for the Hospital)	26,017
Expected benefit payments:	
2011	$ 27,407
2012	25,151
2013	28,085
2014	28,660
2015	30,834
2016 through 2020	180,959

Management evaluates its Plan assumptions annually and the expected contributions in 2011 could increase.

Other Postretirement Benefits

In addition to providing pension benefits, the Hospital provides certain health care and life insurance benefits to retired employees. As of December 31, 2003, health care and life insurance postretirement benefits were eliminated for all active employees of the Hospital with fewer than fifteen years of consecutive service. The Hospital's postretirement plan is not expected to be materially affected by health care reform legislation.

The Hospital recognizes in its consolidated statements of financial position an asset for a benefit plan's overfunded status or a liability for a plan's underfunded status, and recognizes changes in that funded status in the year in which the changes occur through changes in unrestricted net assets. The funded-status

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

amount is measured as the difference between the fair value of plan assets and the benefit obligation including all actuarial gains and losses and prior service cost. Based on September 30, 2010 funded-status amounts for the Hospital's postretirement benefit plan, the Hospital recorded a decrease in unrestricted net assets of $797.

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement benefit cost in 2011 are as follows:

Net actuarial loss	$ 171
Prior service benefit	(639)
	$ (468)

Benefit Obligations

	2010	2009
Change in accumulated postretirement benefit obligation:		
Accumulated postretirement benefit obligation at beginning of year	$ 21,916	$ 22,916
Service cost	410	483
Interest cost	1,220	1,546
Benefits paid	(1,311)	(1,711)
Actuarial loss (gain)	85	(1,825)
Service cost and interest cost for July 1 – September 30, 2008	—	507
Accumulated postretirement benefit obligation at end of year	$ 22,320	$ 21,916

Funded Status

The Hospital has never funded its other postretirement benefit obligations. The funded status of the postretirement benefit plan, reconciled to the amount reported in the consolidated statements of financial position, follows:

	2010	2009
Benefit obligations	$ 22,320	$ 21,916
Funded status	(22,320)	(21,916)
Accrued postretirement benefit cost recognized in the consolidated statements of financial position	$ (22,320)	$ (21,916)

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

Amounts recognized in the consolidated statements of financial position at September 30, 2010 and 2009 consist of:

	2010	2009
Accrued postretirement benefit cost:		
Current (included in accrued employee benefits and compensation)	$ 1,425	$ 1,348
Noncurrent (included in other liabilities)	20,895	20,568
Total accrued postretirement benefit cost	$ 22,320	$ 21,916

	2010	2009
Amounts not yet reflected in net periodic postretirement benefit cost and included in unrestricted net assets:		
Prior service benefit	$ 639	$ 1,488
Accumulated net actuarial loss	(3,768)	(3,856)
Amounts not yet recognized as a component of net periodic postretirement benefit cost	(3,129)	(2,368)
Accumulated net periodic postretirement benefit cost	(19,191)	(19,548)
Net amount recognized	$ (22,320)	$ (21,916)

	2010	2009
Sources of change in unrestricted net assets:		
Net (loss) gain arising during the year	$ (122)	$ 1,971
Amortizations:		
Net actuarial loss	174	391
Prior service benefit	(849)	(847)
Total unrestricted net asset (loss) gain recognized during the year	$ (797)	$ 1,515

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

Net Periodic Postretirement Benefit Cost

Components of net periodic postretirement benefit cost are as follows for the years ended September 30:

	2010	2009
Service cost	$ 410	$ 483
Interest cost	1,220	1,546
Amortization of prior service benefit	(849)	(847)
Amortization of net actuarial loss	174	391
Net periodic postretirement benefit cost	$ 955	$ 1,573

The following weighted average assumptions were used by the Plan's actuary to determine net periodic postretirement benefit cost and benefit obligations:

	2010	2009
Discount rate for benefit obligations	4.98%	5.74%
Discount rate for net periodic postretirement benefit cost	5.74	6.92

Assumed Health Care Cost Trend Rates at September 30:

	2010	2009
Health care cost trend rate assumed for next year	8.03%	8.00%
Rate to which the cost trend rate is assumed to decline (the ultimate trend rate)	4%	5%
Year that the rate reaches the ultimate trend rate	2029	2015

Assumed health care cost trend rates have a significant effect on the amounts reported. A one-percentage-point increase in assumed health care cost trend rates would have the following effects as of September 30, 2010:

	1-Percentage-Point Increase	1-Percentage-Point Decrease
Effect on total of service cost and interest cost	$ 138	$ (124)
Effect on accumulated postretirement benefit obligation	1,621	(1,469)

(Continued)

(In thousands)

(8) Pension and Other Postretirement Benefits (continued)

Expected Cash Flows

Information about the expected cash flows for the postretirement benefit plan follows:

Expected benefit payments:		
2011	$	1,425
2012		1,556
2013		1,687
2014		1,789
2015		1,925
2016 through 2020		10,448

(9) Patient Service Revenue and Related Reimbursement

A major portion of the Hospital's revenue is received from third-party payors. The following is an approximate percentage breakdown of gross patient service revenue by payor type for the years ended September 30:

	2010	2009
Medicare and Senior Care	36%	35%
Blue Cross	19	20
Medicaid and RIte Care	19	19
Managed care	12	13
Commercial, self-pay, and other	14	13
	100%	100%

The Hospital grants credit to patients, most of whom are local residents. The Hospital generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, Blue Cross, managed care, and commercial insurance policies).

Cost reports filed annually with third-party payors are subject to audit prior to final settlement. The 2010 cost reports have not been filed and, therefore, not settled with either Medicare or Medicaid. In addition, the Medicare cost reports for 2007 through 2009 and the Medicaid cost reports for 2005 through 2009 have not been settled.

Regulations in effect require annual settlements based upon cost reports filed by the Hospital. These settlements are estimated and recorded in the accompanying consolidated financial statements. Changes in these estimates are reflected in the consolidated financial statements in the year in which they occur. Net patient service revenue in the accompanying consolidated statements of operations and changes in net assets was increased by $7,852 and $2,243 in 2010 and 2009, respectively, to reflect changes in the estimated settlements for certain prior years.

(Continued)

(9) Patient Service Revenue and Related Reimbursement (continued)

Revenues from Medicare and Medicaid programs accounted for approximately 36% and 19%, respectively, of the Hospital's gross patient service revenue for the year ended September 30, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations. The Hospital is responding to a recent investigation by the United States Department of Justice and the United States Department of Health and Human Services, Office of the Inspector General, dealing with the medical necessity of a limited number of Medicare inpatient claims. It is not possible to state at this time whether and to what extent liability will be imposed or a settlement will be reached. While the Hospital intends to continue to defend the matter vigorously, the Civil False Claims Act (the Act) contains provisions of the imposition of double and treble damages and civil penalties upon finding that the Act was violated, which could result in material liability. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action; failure to comply with such laws and regulations can result in fines, penalties and exclusion from Medicare and Medicaid programs.

(10) Income Tax Status

The Hospital and its affiliates are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from Federal income taxes pursuant to Section 501 (a) of the Code.

(Continued)

(In thousands)

(11) Long-Term Debt

Long-term debt consists of the following at September 30:

	2010	2009
Hospital Financing Revenue fixed rate serial and term bonds due May 15, 2011 through 2032 in annual amounts ranging from $6,875 to $15,020 at rates ranging from 4% to 5% (2006A Series – Lifespan Obligated Group)	$ 146,174	$ 151,444
Hospital Financing Revenue fixed rate serial and term bonds due May 15, 2027 through 2039 in annual amounts ranging from $1,870 to $7,900 at rates ranging from 6.125% to 7% (2009A Series – Lifespan Obligated Group)	72,441	72,441
Hospital Financing Revenue fixed rate serial and term bonds due May 15, 2011 through 2026 in annual amounts ranging from $655 to $14,705 at rates ranging from 5.4% to 5.75% (1996 Series – Lifespan Obligated Group)	44,517	45,033
Hospital Financing Revenue fixed rate serial and term bonds due August 15, 2011 through 2012 in annual amounts ranging from $1,500 to $1,595 at 6.375% (2002 Series – Lifespan Obligated Group)	2,321	3,386
Unamortized premium – 2006A Series	5,019	5,558
Unamortized premium – 2009A Series	122	127
Unamortized discount – 1996 and 2002 Series	(15)	(30)
	270,579	277,959
Less current portion	7,152	6,851
Long-term debt, excluding current portion	$ 263,427	$ 271,108

The estimated fair value of the Hospital's long-term debt at September 30, 2010 approximates $273,829 and is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements.

On July 8, 2008, the Board of Directors of Lifespan Corporation, acting as the sole corporate member of Emma Pendleton Bradley Hospital (EPBH), adopted a resolution authorizing EPBH to become a member of the Lifespan Obligated Group. The EPBH Board of Trustees, as well as the Boards of the Hospital and TMH, also authorized related resolutions.

(Continued)

(In thousands)

(11) Long-Term Debt (continued)

On March 30, 2009, Rhode Island Health and Educational Building Corporation (RIHEBC) issued, on behalf of the Lifespan Obligated Group, which consists of the Hospital, TMH, EPBH, Rhode Island Hospital Foundation (RIHF) and The Miriam Hospital Foundation (TMHF), $114,985 of tax-exempt bonds (the 2009A Bonds) for the purposes of financing the acquisition, construction, renovation, expansion and equipping of certain hospital and related health care facilities owned and operated by the Hospital, TMH and EPBH (the Obligated Group Hospitals), including the expansion, construction, renovation, equipping and furnishing of a two-story addition to EPBH's existing building and the renovation of vacated space in the existing building.

The above outstanding 2009 Hospital Financing Revenue Bonds (Lifespan Obligated Group – the Hospital, TMH, EPBH, RIHF and TMHF) are secured by a pledge of the gross receipts of the Obligated Group Hospitals and by mortgage liens on the Hospital's and TMH's real property and all buildings, structures and improvements thereon. The Obligated Group Hospitals, RIHF and TMHF are jointly and severally liable for repayment of the 2009A Bonds, recorded directly by the Obligated Group Hospitals as follows:

The Hospital	$ 72,441
TMH	19,547
EPBH	22,997
Total	$ 114,985

Payment of the principal amount of and interest on $64,825 of the 2009A Bonds when due is guaranteed by a financial guaranty insurance policy issued by Assured Guaranty Corp.

On February 14, 2006, RIHEBC issued, on behalf of the Lifespan Obligated Group, $192,135 of tax-exempt bonds (the 2006A Bonds) for the purpose of refunding $123,405 and $65,315 of the Lifespan Obligated Group's 1996 Bonds and 2002 Bonds, respectively. The advance refundings were allocated as follows:

	1996 Bonds	2002 Bonds
The Hospital	$ 101,809	$ 48,986
TMH	21,596	16,329
Total	$ 123,405	$ 65,315

On September 12, 2006, the Board of Directors of Lifespan Corporation, acting as the sole corporate member of each of The Miriam Hospital Foundation and Rhode Island Hospital Foundation (the Foundations), adopted resolutions authorizing the Foundations to become members of the Lifespan Obligated Group. The Boards of Trustees of each of the Foundations, as well as the then existing members of the Lifespan Obligated Group, the Hospital and TMH, previously authorized related resolutions. The effective date for such change was October 1, 2006.

(Continued)

(11) Long-Term Debt (continued)

The above outstanding 2006 Hospital Financing Revenue Bonds (Lifespan Obligated Group – the Hospital, TMH, EPBH and the Foundations) are secured by a pledge of the gross receipts of the Hospital and TMH and by mortgage liens on the Hospital's and TMH's real property and all buildings, structures and improvements thereon. The Obligated Group Hospitals and the Foundations are jointly and severally liable for repayment of the 2006A Bonds, $146,174 and $37,001 of which has been recorded directly by the Hospital and TMH, respectively. Payment of the principal and interest on the 2006A Bonds when due is guaranteed by a financial guaranty insurance policy issued by Assured Guaranty Corp.

On July 9, 2002, RIHEBC issued, on behalf of the Lifespan Obligated Group, $78,000 of tax-exempt bonds (the 2002 Bonds) to finance routine capital expenditures of the Hospital and TMH, renovations of the RIH emergency department and construction and equipping of a cancer center on the campus of RIH.

The above outstanding 2002 Hospital Financing Revenue Bonds (Lifespan Obligated Group – the Hospital, TMH, EPBH and the Foundations) are secured by mortgage liens on the Hospital's and TMH's real property and all buildings, structures and improvements thereon. The Obligated Group Hospitals and the Foundations are jointly and severally liable for repayment of the 2002 Bonds, $2,321 and $774 of which has been recorded directly by the Hospital and TMH, respectively.

On December 1, 1996, RIHEBC issued, on behalf of the Lifespan Obligated Group, $214,585 of tax-exempt bonds (the 1996 Bonds), to finance portions of Lifespan's, the Hospital's and TMH's 1996, 1997, 1998 and 1999 expenditures for routine capital equipment and facility renovation/replacement, and to advance refund $8,455 of TMH 1989 Series A bonds, $1,900 of TMH 1992 Series A bonds and $10,065 of TMH 1992 Series B bonds.

The above outstanding 1996 Hospital Financing Revenue Bonds (Lifespan Obligated Group – the Hospital, TMH, EPBH and the Foundations) are secured by a pledge of the gross receipts of the Hospital and TMH. The Obligated Group Hospitals and the Foundations are jointly and severally liable for repayment of the 1996 Bonds, $44,517 and $9,443 of which has been recorded directly by the Hospital and TMH, respectively. Payment of the principal and interest on the 1996 Bonds when due is guaranteed by a financial guaranty insurance policy issued by National Public Finance Guarantee Corp.

Under the terms of the 2009A, 2006A, 2002 and 1996 Bonds, the Obligated Group Hospitals are required to satisfy certain measures of financial performance as long as the bonds are outstanding. At September 30, 2010, management believes the Obligated Group Hospitals were in compliance with all covenants of the bonds.

The Hospital's aggregate maturities of long-term debt for the five fiscal years ending in September 2015 are as follows: 2011, $7,152; 2012, $7,523; 2013, $7,987; 2014, $8,396; and 2015, $8,816.

(Continued)

(In thousands)

(11) Long-Term Debt (continued)

Agreements underlying the various Hospital Financing Revenue Bonds require that the Obligated Group Hospitals maintain certain trustee-held funds, included with assets limited as to use in the consolidated statements of financial position, as follows:

Project Fund – The Obligated Group Hospitals are required to apply monies in the Project Fund to pay the costs of debt issuance, facility renovation/replacement, and routine capital equipment.

Bond Funds – The Obligated Group Hospitals are required to make periodic deposits to the trustee sufficient to provide sinking funds for the payment of principal and interest to bondholders when due.

Debt Service Reserve Funds – The Obligated Group Hospitals are required to apply monies in the Debt Service Reserve Funds to remedy deficiencies in the Bond Funds, if any.

The Hospital's trustee-held funds at September 30 are summarized as follows:

	2010	2009
Project Fund – 2009A Series	$ 26,947	$ 39,450
Bond Funds	890	2
Debt Service Reserve Funds – 2009A Series	7,246	7,246
Debt Service Reserve Funds – 2002 Series	232	390
Total	$ 35,315	$ 47,088

(12) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
General health care service activities	$ 153,092	$ 141,656
Research	53,864	50,666
Interest in net assets of Rhode Island Hospital Foundation	14,287	15,056
Total	$ 221,243	$ 207,378

(Continued)

(In thousands)

(12) Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets are restricted in perpetuity at September 30, the income from which is expendable to support the following:

	2010	2009
General health care service activities	$ 33,490	$ 32,905
Research	4,995	4,995
Interest in net assets of Rhode Island Hospital Foundation	28,944	19,114
Total	$ 67,429	$ 57,014

Permanently restricted net assets increased by $10,415 in the year ended September 30, 2010 primarily due to a gift in the amount of $9,655 received from the Frederick Henry Prince Trust. The income on this endowment will be used to support the Hospital's Neurosciences Institute.

(13) Leases

The Hospital leases building space and equipment under various noncancelable operating lease agreements. Future minimum lease payments, by year and in the aggregate, under noncancelable operating leases with terms of one year or more consist of the following at September 30, 2010:

	Amount
Year ending September 30:	
2011	$ 5,042
2012	4,484
2013	4,066
2014	2,907
2015	1,434
Thereafter	1,128
Total minimum lease payments	$ 19,061

Rental expense, including rentals under leases with terms of less than one year, for the years ended September 30, 2010 and 2009 was $9,391 and $8,698, respectively.

(14) Concentrations of Credit Risk

Financial instruments which potentially subject the Hospital to concentrations of credit risk consist primarily of accounts receivable and certain investments. The risk associated with temporary cash investments is mitigated by the fact that the investments are placed with what management believes are high credit quality financial institutions. Investments, which include government and agency obligations, stocks, and corporate bonds, are not concentrated in any corporation or industry.

(Continued)

(14) Concentrations of Credit Risk (continued)

The Hospital receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payors, including Medicare, Blue Cross, Medicaid, and various managed care entities. The Hospital has not historically incurred any significant concentrated credit losses in the normal course of business.

(15) Malpractice and Other Litigation

Professional Liability/Medical Malpractice and General Liability

Professional liability/medical malpractice coverage for the Hospital is supplied on a claims-made basis by Rhode Island Sound Enterprises Insurance Co. Ltd. (RISE), Lifespan's affiliated captive insurance company, which underwrites the medical malpractice risk of the Hospital (including the Hospital's contractual commitment to indemnify certain eligible nonemployed physicians). The adequacy of the coverage provided and the funding levels are reviewed annually by independent actuaries and consultants. The professional liability/medical malpractice insurance provided by RISE has liability limits of $4,000 per claim with no annual aggregate. RISE provides a second layer of coverage which has limits of an additional $2,000 per claim with a $2,000 annual aggregate. In addition, commercial umbrella excess insurance has been obtained by Lifespan to increase the professional liability limits to $26,000 per claim. Also covered under the Hospital's professional liability/medical malpractice policy are 538 nonemployed physicians. Each of these physicians is provided with a $2,000 indemnification per claim and a $6,000 annual indemnification aggregate.

The Hospital or its indemnified physicians have been named as defendants in a number of pending actions seeking damages for alleged medical malpractice liability. In the opinion of management, any liability and legal defense costs resulting from these actions will be within the limits of the Hospital's malpractice insurance coverage provided by RISE and/or commercial excess carriers.

General liability coverage is provided to the Hospital by RISE amounting to $4,000 per claim and $4,000 in the annual aggregate. Commercial excess liability insurance has been obtained by Lifespan which provides aggregate general liability coverage of $80,000.

Workers' Compensation

The Hospital has incurred a number of workers' compensation claims and, in the opinion of management, the liability of the Hospital will be within the limits of the assets of Lifespan's workers' compensation self-insurance trust fund.

Other Litigation

The Hospital is also involved in a number of miscellaneous suits and general liability suits arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's future financial position or results from operations.

(Continued)

(In thousands)

(16) Related-Party Transactions

The Hospital rents space and provides laundry and linen services to affiliates. Included in the Hospital's other revenue in the consolidated statements of operations and changes in net assets are the following amounts resulting from transactions with affiliates for the years ended September 30:

	2010	2009
Rental income	$ 3,439	$ 3,411
Services rendered – laundry and linen	1,597	1,578
Total	$ 5,036	$ 4,989

The Hospital was charged a management fee by Lifespan of $68,477 and $68,189 in 2010 and 2009, respectively, representing approximately 68% and 65%, respectively, of Lifespan's operating expenses. Lifespan provides information services, human resources, financial, and various other support services to the Hospital.

Included in other receivables and other accrued expenses in the consolidated statements of financial position are the following amounts due from (to) certain related entities at September 30:

	2010	2009
Other receivables:		
Lifespan	$ 2,533	$ —
TMH	—	941
EPBH	54	113
Rhode Island Hospital Foundation	(2)	27
Total	$ 2,585	$ 1,081
Other accrued expenses:		
Lifespan	$ —	$ (296)
TMH	(100)	—
Newport Hospital	(386)	(208)
Total	$ (486)	$ (504)

During the years ended September 30, 2010 and 2009, the Hospital received temporarily restricted net asset transfers from Rhode Island Hospital Foundation (the Foundation) amounting to $5,292 and $6,033, respectively.

(Continued)

(In thousands)

(16) Related-Party Transactions (continued)

The Foundation, whose sole corporate member is Lifespan Corporation, was established to engage in philanthropic activities to support the mission and purposes of Lifespan and the Hospital. Funds are distributed to the Hospital when purpose restrictions stipulated by donors are accomplished, or as determined by the Boards of Trustees of the Hospital and the Foundation. A summary of the Foundation's assets, liabilities, net assets, deficiency of revenues over expenses, and changes in net assets follows. The Hospital's interest in the net assets of the Foundation is reported as a noncurrent asset in the consolidated statements of financial position.

	2010	2009
Assets, principally assets limited as to use	$ 51,075	$ 42,699
Liabilities	$ 318	$ 147
Unrestricted net assets	7,526	8,382
Temporarily restricted net assets	14,287	15,056
Permanently restricted net assets	28,944	19,114
Total liabilities and net assets	$ 51,075	$ 42,699
Total unrestricted revenues, gains and other support	$ 3,233	$ 1,437
Total expenses	4,598	4,857
Deficiency of revenues over expenses	(1,365)	(3,420)
Other increases (decreases) in unrestricted net assets	509	(270)
Unrestricted net assets, beginning of year	8,382	12,072
Unrestricted net assets, end of year	$ 7,526	$ 8,382
Net (decrease) increase in temporarily restricted net assets	$ (769)	$ 703
Temporarily restricted net assets, beginning of year	15,056	14,353
Temporarily restricted net assets, end of year	$ 14,287	$ 15,056
Increase (decrease) in permanently restricted net assets	$ 9,830	$ (4,272)
Permanently restricted net assets, beginning of year	19,114	23,386
Permanently restricted net assets, end of year	$ 28,944	$ 19,114

(Continued)

(In thousands)

(17) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows for the years ended September 30:

	2010	2009
Health care services	$ 824,396	$ 790,425
Research	62,642	54,437
General and administrative:		
Depreciation and amortization	33,727	32,698
Interest	14,394	12,094
Other	77,419	74,264
Total general and administrative	125,540	119,056
	$ 1,012,578	$ 963,918

(18) Combination of RIH and TMH

In 2009, Lifespan announced its intention to combine the Hospital and TMH into a single hospital with two campuses. Rhode Island Hospital Foundation and The Miriam Hospital Foundation will remain as separate entities. The hospitals do not expect the elimination of services or a significant loss of jobs. The plan will be subject to applicable State regulatory approvals.

(19) Subsequent Event

On November 23, 2010, the Hospital announced a voluntary early retirement program which is designed to provide salary and benefits continuation for eligible employees who wish to retire. The cost of this program, which will be recorded in 2011, is not currently known.

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Financial Position

September 30, 2011 and 2010

(In thousands)

Assets	2011	2010
Current assets:		
Cash and cash equivalents	$ 22,610	$ 47,816
Patient accounts receivable	174,017	172,192
Less allowance for doubtful accounts	(46,535)	(42,876)
Net patient accounts receivable	127,482	129,316
Other receivables	21,216	23,206
Total receivables	148,698	152,522
Assets limited as to use	729	890
Inventories	12,282	12,020
Prepaid expenses and other current assets	2,083	2,040
Total current assets	186,402	215,288
Interest in net assets of Rhode Island Hospital Foundation	51,844	50,757
Assets limited as to use	502,444	510,927
Less amount required to meet current obligations	(729)	(890)
Noncurrent assets limited as to use	501,715	510,037
Property and equipment, net	501,134	494,584
Other assets:		
Deferred charges and financing costs, net	6,363	6,911
Other noncurrent assets	705	1,733
Total other assets	7,068	8,644
Total assets	$ 1,248,163	$ 1,279,310

Liabilities and Net Assets	2011	2010
Current liabilities:		
Accounts payable	$ 37,664	$ 35,619
Accrued employee benefits and compensation	26,869	32,417
Other accrued expenses	32,611	23,792
Current portion of long-term debt	7,523	7,152
Current portion of estimated third-party payor settlements	16,845	20,146
Estimated health care benefit self-insurance costs	3,128	3,955
Total current liabilities	124,640	123,081
Long-term debt, net of current portion	255,390	263,427
Estimated third-party payor settlements, net of current portion	25,824	42,324
Accrued pension liability	124,624	125,337
Other liabilities	26,560	23,235
Total liabilities	557,038	577,404
Net assets:		
Unrestricted	400,847	413,234
Temporarily restricted	218,428	221,243
Permanently restricted	71,850	67,429
Total net assets	691,125	701,906
Total liabilities and net assets	$ 1,248,163	$ 1,279,310

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2011	**2010**	**2011**	**2010**
Unrestricted revenues and other support:				
Net patient service revenue	$ 238,576	$ 236,183	$ 965,335	$ 918,658
Other revenue	7,556	9,375	33,244	36,738
Endowment earnings contributed toward community benefit	2,030	2,835	7,998	7,822
Net assets released from restrictions used for operations	4,972	6,821	19,105	18,627
Net assets released from restrictions used for research	15,106	14,150	53,564	52,845
Total unrestricted revenues and other support	268,240	269,364	1,079,246	1,034,690
Operating expenses:				
Compensation and benefits	141,930	137,980	594,260	549,892
Supplies and other expenses	55,546	59,536	204,921	212,888
Purchased services	31,436	21,840	119,408	106,245
Provision for bad debts	17,764	15,222	62,147	54,199
Depreciation and amortization	8,730	8,597	34,682	33,727
Interest	3,455	3,541	14,084	14,394
License fees	11,232	10,308	44,926	41,233
Total operating expenses	270,093	257,024	1,074,428	1,012,578
(Loss) income from operations	(1,853)	12,340	4,818	22,112
Nonoperating gains and losses:				
Net realized (losses) gains on board-designated investments	(5,934)	3,328	(1,912)	2,073
Litigation settlement	(8,359)	—	(8,359)	—
Other nonoperating gains	—	556	52	560
Total nonoperating (losses) gains, net	(14,293)	3,884	(10,219)	2,633
(Deficiency) excess of revenues over expenses	$ (16,146)	$ 16,224	$ (5,401)	$ 24,745

RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Operations and Changes in Net Assets (continued)

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2011	2010	2011	2010
Unrestricted net assets:				
(Deficiency) excess of revenues over expenses	$ (16,146)	$ 16,224	$ (5,401)	$ 24,745
Other changes in unrestricted net assets:				
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	(40,411)	(20,017)	(10,237)	(20,017)
Net change in unrealized gains on investments	(6,868)	7,491	(566)	9,953
Net assets released from restrictions used for purchase of property and equipment	1,838	1,617	4,970	4,766
Other	(466)	1,137	(1,153)	(879)
(Decrease) increase in unrestricted net assets	(62,053)	6,452	(12,387)	18,568
Temporarily restricted net assets:				
Gifts, grants and bequests	18,681	16,307	63,701	63,996
Income from restricted endowment and other restricted investments	555	575	2,500	2,664
Transfers from RIH Foundation	979	1,077	8,292	5,292
Net assets released from restrictions	(21,916)	(22,588)	(77,639)	(76,238)
Net realized and unrealized (losses) gains on investments	(14,095)	14,463	3,549	18,920
Other	(2,691)	989	(3,218)	(769)
(Decrease) increase in temporarily restricted net assets	(18,487)	10,823	(2,815)	13,865
Permanently restricted net assets:				
Net unrealized (losses) gains on investments	(568)	585	(568)	585
Other	3,256	9,609	4,989	9,830
Increase in permanently restricted net assets	2,688	10,194	4,421	10,415
(Decrease) increase in net assets	(77,852)	27,469	(10,781)	42,848
Net assets, beginning of period	768,977	674,437	701,906	659,058
Net assets, end of period	$ 691,125	$ 701,906	$ 691,125	$ 701,906

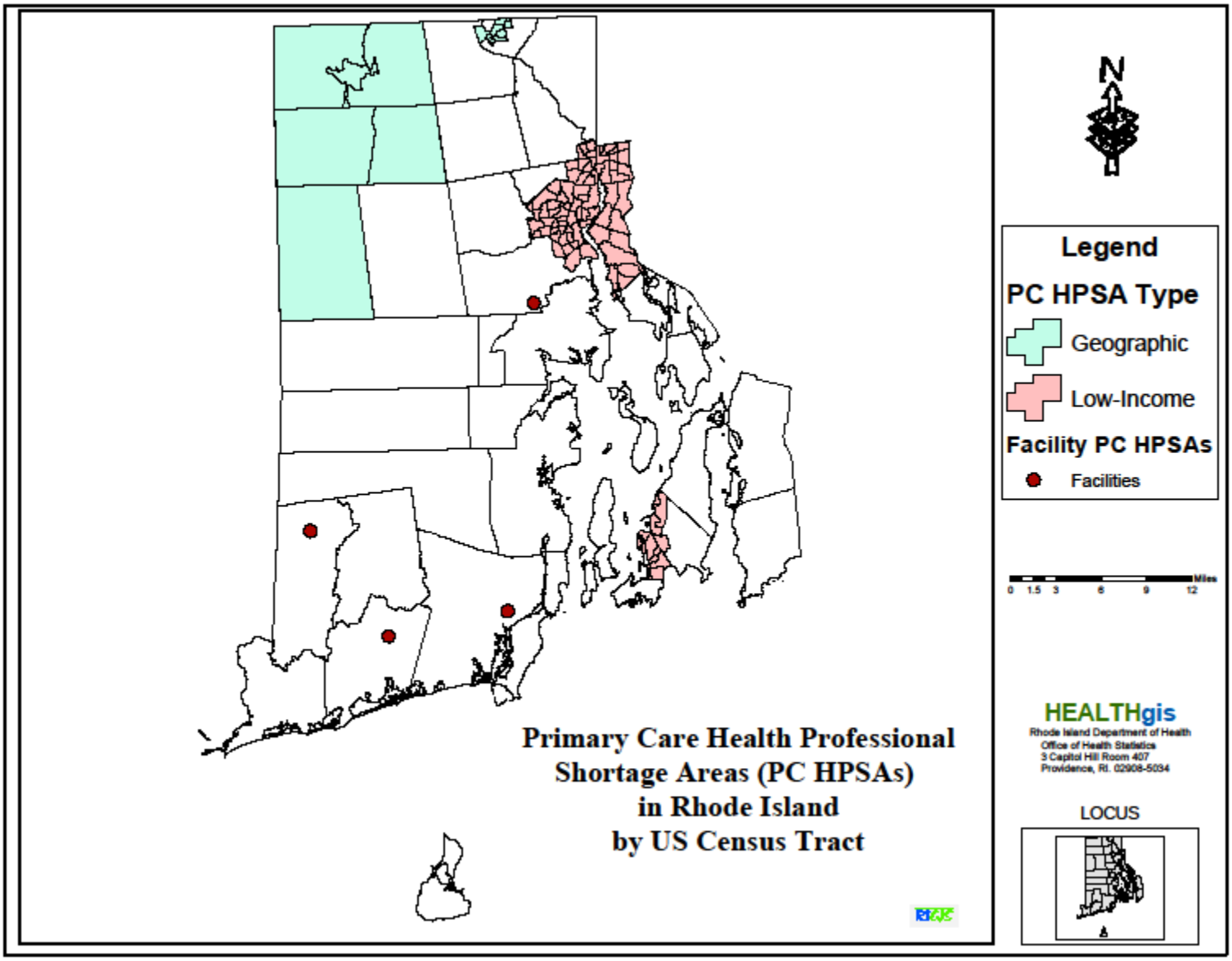
RHODE ISLAND HOSPITAL AND AFFILIATES

Consolidated Statements of Cash Flows

(In thousands)

	Fourth Quarter Ended September 30		Year Ended September 30	
	2011	2010	2011	2010
Cash flows from operating activities:				
(Decrease) increase in net assets	$ (77,852)	$ 27,469	$ (10,781)	$ 42,848
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:				
Change in funded status of pension and other postretirement plans, other than net periodic pension and postretirement benefit costs	40,411	20,017	10,237	20,017
Net realized and unrealized losses (gains) on investments	27,465	(25,867)	(503)	(31,531)
Undistributed portion of change in interest in net assets of Rhode Island Hospital Foundation	(195)	(11,880)	(1,087)	(8,205)
Transfers from Rhode Island Hospital Foundation	(979)	(1,077)	(8,292)	(5,292)
Depreciation and amortization	8,730	8,597	34,682	33,727
Provision for estimated health care benefit self-insurance costs	13,132	14,304	57,150	55,248
Decrease in liabilities for estimated health care benefit self-insurance costs resulting from claims paid	(13,446)	(13,890)	(57,977)	(55,771)
Net decrease (increase) in patient accounts receivable	3,960	(6,564)	1,834	(12,707)
Increase in accounts payable	8,195	7,305	2,045	3,130
Decrease in accrued employee benefits and compensation	(11,947)	(3,138)	(5,548)	(7,162)
Decrease in estimated third-party payor settlements	(3,672)	(891)	(19,801)	(2,969)
Increase in all other current and noncurrent assets and liabilities, net	18,861	11,261	3,393	4,796
Net cash provided by operating activities	12,663	25,646	5,352	36,129
Cash flows from investing activities:				
Purchase of property and equipment	(14,869)	(10,859)	(40,684)	(38,449)
Net decrease in trustee-held bond funds	1,475	1,199	11,711	11,773
Other net decreases (increases) in assets limited as to use	1,712	(36,168)	(2,725)	(42,005)
Net cash used in investing activities	(11,682)	(45,828)	(31,698)	(68,681)
Cash flows from financing activities:				
Payments on long-term debt	(1,125)	(1,065)	(7,152)	(6,851)
Transfers from Rhode Island Hospital Foundation	979	1,077	8,292	5,292
Net cash (used in) provided by financing activities	(146)	12	1,140	(1,559)
Net increase (decrease) in cash and cash equivalents	835	(20,170)	(25,206)	(34,111)
Cash and cash equivalents, beginning of period	21,775	67,986	47,816	81,927
Cash and cash equivalents, end of period	$ 22,610	$ 47,816	$ 22,610	$ 47,816

ATTACHMENT 3 - HEALTH PROFESSIONAL SHORTAGE AREAS MAP AND TABLES



Health Professional Shortage Areas in Rhode Island

December 2003

Primary Care HPSAs

CITY/TOWN	SERVICE AREA/ CENSUS TRACTS	PC-HPSA TYPE	PC-HPSA ID#	HPSA Score	LAST UPDATED
BURRILLVILLE FOSTER GLOCESTER (NORTHWEST PROVIDENCE COUNTY)	ALL BURRILLVILLE (CTs 129-130.02); ALL FOSTER (CT 133); ALL GLOCESTER (CTs 131.01, 131.02)	GEOGRAPHIC	144999-4407	10	Sep-01
CENTRAL FALLS PAWTUCKET	ALL CENTRAL FALLS (CTs 108-111) ALL PAWTUCKET (CTs 149-171)	LOW-INCOME POPULATION	144999-4418	10	Jun-00
CHARLESTOWN	NARRAGANSETT INDIAN TRIBE	NATIVE AMERICAN POPULATION	144999-4415	12	Feb-99
CRANSTON	ADULT CORRECTIONS INSTITUTE (ACI)	CORRECTIONAL FACILITY	144999-4405	15	Nov-01
EAST PROVIDENCE	ALL EAST PROVIDENCE (CTs 101.1-107.02)	LOW-INCOME POPULATION	144999-4419	7	Nov-01
HOPKINTON (HOPE VALLEY)	WOOD RIVER HEALTH SERVICES, INC.	NON-PROFIT MEDICAL FACILITY	144999-4416	12	Feb-99
NEWPORT MIDDLETOWN	MIDDLETOWN - PARTIAL (CTs 402, 403.02, 403.03); NEWPORT - PARTIAL (CTs 405-408, 410, 412)	LOW-INCOME POPULATION	144999-4414	6	Oct-00
PROVIDENCE	ALL PROVIDENCE (CTs 1-37)	LOW-INCOME POPULATION	144999-4412	10	Jun-00
SOUTH KINGSTOWN (WAKEFIELD)	HEALTH CENTER OF SOUTH COUNTY	NON-PROFIT MEDICAL FACILITY	144999-4417	6	Feb-99
WOONSOCKET	WOONSOCKET - PARTIAL (CTs 172, 174, 176, 178-182)	GEOGRAPHIC	144999-4404	7	May-00

Health Professional Shortage Areas in Rhode Island

December 2003

Dental HPSAs

CITY/TOWN	SERVICE AREA/ CENSUS TRACTS	DHPSA TYPE	DHPSA ID#	DHPSA SCORE	LAST UPDATED
CENTRAL FALLS PAWTUCKET	ALL CENTRAL FALLS (CTs 108-111) ALL PAWTUCKET (CTs 149-171)	LOW-INCOME POPULATION	644999-4405	14	Jun-00
CHARLESTOWN	NARRAGANSETT INDIAN TRIBE	NATIVE AMERICAN POPULATION	644999-4409	19	Feb-99
CRANSTON	ADULT CORRECTIONS INSTITUTE (ACI)	CORRECTIONAL FACILITY	644999-4413	15	Nov-01
HOPKINTON (HOPE VALLEY)	WOOD RIVER HEALTH SERVICES, INC.	NON-PROFIT DENTAL FACILITY	644999-4412	19	Nov-00
NEWPORT MIDDLETOWN	MIDDLETOWN - PARTIAL (CTs 402, 403.02, 403.03); NEWPORT - PARTIAL (CTs 405-408, 410, 412)	LOW-INCOME POPULATION	644999-4411	6	Mar-00
PROVIDENCE	ALL PROVIDENCE (CTs 1-37)	LOW-INCOME POPULATION	644999-4406	14	Feb-01
SOUTH KINGSTOWN (WAKEFIELD)	HEALTH CENTER OF SOUTH COUNTY	NON-PROFIT DENTAL FACILITY	644999-4410	0	Feb-99
WOONSOCKET/ NORTHWEST PROVIDENCE COUNTY	ALL BURRILLVILLE (CTs 129-130.02) ALL FOSTER (CT 133) ALL GLOCESTER (CTs 131.01, 131.02) ALL NORTH SMITHFIELD (CTs 128.01-128.03) ALL WOONSOCKET (CTs 173-185)	LOW-INCOME POPULATION	644999-4408	10	Oct-00

Health Professional Shortage Areas in Rhode Island

December 2003

Mental Health HPSAs

CITY/TOWN	SERVICE AREA/ CENSUS TRACTS	MH-HPSA TYPE	MH-HPSA ID#	MH-HPSA SCORE	LAST UPDATED
CHARLESTOWN	NARRAGANSETT INDIAN TRIBE	NATIVE AMERICAN POPULATION	744999-4408	17	Feb-99
CRANSTON	ADULT CORRECTIONS INSTITUTE (ACI)	CORRECTIONAL FACILITY	744999-4410	15	Nov-01
CRANSTON	ELEANOR SLATER HOSPITAL	FACILITY	744999-4409	8	Nov-01
NEWPORT COUNTY	ALL PORTSMOUTH (CTs 401.01-401.03) ALL MIDDLETOWN (CTs 402, 403.02-403.04, 404) ALL NEWPORT (CTs 405-412) ALL JAMESTOWN (CT 413) ALL LITTLE COMPTON (CT 414) ALL TIVERTON (CTs 416.01-416.02, 417)	GEOGRAPHIC SINGLE COUNTY	744005	10	Jan-03
NORTHERN RHODE ISLAND	ALL CUMBERLAND (CTs 112, 113.01-114.03) ALL LINCOLN (CTs 115-116, 117.01-117.02) ALL NORTH SMITHFIELD (CTs 128.01-128.03) ALL BURRILLVILLE (CTs 129, 130.01-130.02) ALL WOONSOCKET (CTs 173-185)	GEOGRAPHIC	744999-4412	11	Feb-03
PROVIDENCE-PAWTUCKET-CENTRAL FALLS	ALL PROVIDENCE (CTs 1-37) ALL CENTRAL FALLS (CTs 108-111) ALL PAWTUCKET (CTs 150-161, 163-171)	LOW INCOME POPULATION	744999-4411	16	Apr-02

PORTABLE CT SCANNER
ESCROW AGREEMENT – CON

This Agreement is entered into as of January 10, 2012, by and between RHODE ISLAND HOSPITAL, a not-for-profit corporation organized under the laws of the State of Rhode Island, with its principle office located at 593 Eddy Street, Providence, Rhode Island 02903, hereinafter referred to as "Applicant," and CHACE RUTTENBERG & FREEDMAN, LLP, a limited liability partnership organized under the laws of the State of Rhode Island, with its principle office located at One Park Row, Suite 300, Providence, Rhode Island 02903, hereinafter referred to as "Escrow Agent."

The Applicant has submitted an application for a Certificate of Need (CON) with the Rhode Island Department of Health ("State Agency") pursuant to R.I.G.L. 23-15 for the purpose of acquiring and operating a magnetic resonance imaging unit for use in Applicants' Emergency Department. Pursuant to the provisions of R.I.G.L. 23-15-11, the State Agency may, in effectuating the purposes of Chapter 23-15, engage experts or consultants in the review of a CON application and all costs and expenses in connection therewith shall be the responsibility of the Applicant in an amount to be determined by the Director of Health as s/he shall deem appropriate, provided, however, that the maximum cost and expense to an applicant for experts and/or consultants shall be Twenty Thousand Dollars ($20,000.00).

In connection with the foregoing and the Applicant's CON, the State Agency may enter into a Memorandum of Understanding or such other similar agreement with a consultant for the retention of the consultant's services pursuant to the provisions of the aforesaid R.I.G.L. 23-15-11 (the "Memorandum of Understanding"). Pursuant to such Memorandum of Understanding between the State Agency and the Applicant, the cost and expense to the Applicant for the

engagement of such expert and/or consultant is expected to be in an amount not greater than Twenty Thousand Dollars ($20,000).

An escrow agreement between the Applicant and an Escrow Agent is necessary in order to provide an independent third-party fiduciary to handle and manage the funds from which the expert and/or consultant is to be paid. The Escrow Agent herein has agreed to handle and manage the funds which are to be used for the payment of the expert/consultant engaged by the Department in the review of the CON application, which is the subject matter of this Agreement.

In consideration of the matters described above, and the mutual covenants and agreements between the applicant and the Escrow Agent contained in this Agreement, and other good and valuable consideration, the receipt and sufficiency of which are acknowledged herein, the applicant and the Escrow Agent agree as follows:

1. Creation of the Escrow Fund. The Applicant, no later than February 3, 2012, shall deliver to the Escrow Agent the sum of Twenty Thousand Dollars ($20,000) or such lesser amount as the State Agency shall direct, which the Escrow Agent shall hold in escrow. The Escrow Agent shall provide the State Agency with written confirmation of the receipt of the funds. Such sum shall be referred to herein as the "Escrow Fund." The Escrow Fund shall be deposited in the existing non-interest bearing client trust account maintained by the Escrow Agent (the "Escrow Account") and shall be held in such Escrow Account and released from escrow and paid to the expert and/or consultant engaged by the State Agency only in accordance with the written directions of the State Agency and the terms and conditions of this Escrow Agreement.

2. Intentionally omitted.

3. Distribution of Escrow Account. The Escrow Agent shall make payments from the Escrow Account to the expert and/or consultant engaged by the State Agency, in such amounts and at such times as the State Agency may direct. Upon the earlier of (i) the date the State Agency shall determine and so notify the Escrow Agent in writing that the remaining funds in the Escrow Account are not to be paid to such expert and/or consultant, (ii) the date the Escrow Agent receives a copy of a decision rendered by the Director of Health with respect to the Applicant's application, (iii) June 30, 2012, or (iv) the date the Escrow Agent is notified by the State Agency that the Memorandum of Understanding between the State Agency (and/or State) and the expert or consultant retained thereunder to review the Applicant's application has expired or has been terminated, the Escrow Agent shall promptly pay over, in full, any remaining balance to the Applicant.

4. Escrow Agent Responsibilities. The duties of the Escrow Agent pursuant to this Agreement shall be administrative and not discretionary. The Escrow Agent shall be obliged to act only in accordance with written instructions received by it arising out of or in connection with this Agreement, and is authorized and directed to comply with any notices or directives from the Director of Health applicable to this Agreement, whether such notices or directives are consistent or inconsistent with instructions received by the Escrow Agent from the State Agency.

5. Acknowledgement by Escrow Agent. By execution and delivery of this Agreement, the Escrow Agent acknowledges that the terms and conditions of this Agreement are acceptable and agrees to carry out the provisions of this Agreement on its part.

6. Execution Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be regarded as an original, and all of which shall constitute but one in the same instrument.

7. Captions. The captions and headings in this Agreement shall be solely for convenience of reference and shall in no way define, limit or describe the scope or intent of any provisions or sections of this Agreement.

8. Reproduction of Documents. This Agreement and all documents relating thereto, including without limitation, (a) consents, waivers and modifications which hereafter may be executed, and (b) certificates and other information previously or hereafter furnished, may be photocopied or otherwise reproduced, and any such reproduction shall be admissible in evidence as the original itself in any judicial or administrative proceeding, regardless of whether the original is in existence and regardless of whether such reproduction was made by a party in the regular course of business.

9. Force Majeure. Neither the Applicant nor the Escrow Agent shall be responsible for delays or failures in performance resulting from acts beyond its control. Such acts shall include, but not be limited to, acts of God, strikes, lockouts, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failures, earthquakes or other disaster.

10. Address and Account Information. Notices, instructions and other communications hereunder shall be sent:

If to the Escrow Agent to:

Chace Ruttenberg & Freedman, LLP
One Park Row Suite 300
Providence, Rhode Island 02903
Attention: Carl I. Freedman, Esq.

If to the Applicant:

Rhode Island Hospital

593 Eddy Street
Providence, Rhode Island 02903

With a copy to:

Office of the General Counsel
Lifespan Corporation
167 Point Street
Providence, Rhode Island 02903

If to the State Agency:

Department of Health
Division of Health Services Regulations
Three Capitol Hill, Room 416
Providence, Rhode Island 02908

All notices or communications required or permitted to be given hereunder shall be in writing and shall be delivered by hand or sent by facsimile or sent, postage prepaid, by registered, certified or express mail or reputable overnight courier service and shall be deemed given when so delivered by hand, or facsimile, or if mailed, three days after mailing (one business day in the case of express mail or overnight courier service).

11. Successors. This Agreement shall be binding upon, and inure to the benefit of, the heirs, executors, successors and permitted assignees of the parties hereto, and no other person shall have any right, benefit or obligations hereunder.

12. Limitation of Escrow Agent's Duties and Liabilities.

(a) The duties and responsibilities of the Escrow Agent hereunder shall be determined solely by the express provisions of this Agreement, and no other or further duties or responsibilities shall be implied.

(b) The Escrow Agent may rely and shall be protected in acting or refraining from acting upon any written notice, instruction or request provided for and furnished to it pursuant to the terms of this Agreement and believed by it to be genuine and to have been signed or presented by the proper party or parties. The Escrow Agent shall be under no duty to inquire into or investigate the validity, accuracy or content of any document or agreement presented to it. The Escrow Agent shall have no duty to solicit any item which may be due it hereunder.

(c) The Escrow Agent shall not be liable for any action taken or omitted by it in good faith. The Escrow Agent may consult with counsel of its own choice and shall have full and complete authorization and protection for any action taken or omitted by it hereunder in good faith and in accordance with the opinion of such counsel.

13. Applicable Law. This Agreement shall be governed by and construed in accordance with the internal laws (and not the law of conflicts) of the State of Rhode Island.

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed by their respective representatives hereunto authorized as of the day and year first above written.

CHACE RUTTENBERG & FREEDMAN, LLP

By: _____
Carl I. Freedman, Partner

RHODE ISLAND HOSPITAL

By: _____
Timothy J. Babineau, M. D., President
and Chief Executive Officer