



Department of Health

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19 May 2014

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Dear Attorneys Rocha and Russo:

Please find attached Decision with Conditions approval of the Hospital Conversion Applications of the following Transacting Parties: Prospect Medical Holdings, Inc.; Prospect East Hospital Advisory Services, LLC; Prospect East Holdings, Inc.; Prospect CharterCARE, LLC; Prospect CharterCARE RWMC, LLC; Prospect CharterCARE SJHSRI, LLC; and CharterCARE Health Partners; Roger Williams Medical Center and St. Joseph Health Services of Rhode Island.

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

Sincerely,

A handwritten signature in black ink that reads "Michael K. Dexter". The signature is written in a cursive, slightly slanted style.

Michael K. Dexter
Chief
Office of Health Systems Development

cc: Gen Martin, Esq.

Decision
With
Conditions

Application of Prospect Medical Holdings, Inc.,
Prospect East Holdings, Inc., Prospect East Hospital
Services, Inc., Prospect CharterCARE, LLC, Prospect
CharterCARE RWMC, LLC, Prospect CharterCARE, SJHSRI,
LLC
And CharterCARE Health Partners, Roger Williams Medical
Center and St. Joseph Health Services of Rhode Island

Michael Fine, MD
Director of Health
May 19, 2014

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Purpose of this Report

The purpose of this document is to render the Director of Health's final decision pursuant to the "Hospital Conversions Act," Chapter 23-17-14 of the Rhode Island General Laws, as amended (the "Act") as it relates to the hospital conversion application of Prospect Medical Holdings, Inc.; Prospect East Hospital Advisory Services, LLC; Prospect East Holdings, Inc.; Prospect CharterCARE, LLC; Prospect CharterCARE RWMC, LLC; Prospect CharterCARE SJHSRI, LLC (hereinafter, collectively referred to as "Prospect"); and CharterCARE Health Partners; Roger Williams Medical Center and St. Joseph Health Services of Rhode Island (hereinafter, collectively referred to as "CCHP"). It will discuss the eight criteria set forth in sections 23-17.14-8 and 23-17.14-28(a) of the Rhode Island General Laws, as amended, that the Department is directed to consider as part of its analysis and final decision.

Introduction & Statutory Authority

Since 1997, in Rhode Island, changes in hospital ownership and control are governed by the provisions of the Act.

The purpose of the Act, in pertinent part, is to: (1) assure the viability of a safe, accessible and affordable healthcare system that is available to all of the citizens of the state; (2) establish a process to review whether for-profit hospitals will maintain, enhance, or disrupt the delivery of healthcare in the state; and (3) monitor hospital performance to assure that standards for the community benefits continue to be met.

In this matter, the buyer/acquirer (Prospect) is an out-of-state for-profit hospital chain based in California. The seller/acquiree (CCHP) are not-for-profit corporations.

Hospital Conversion Application Travel

On October 18, 2013, the transacting parties filed an initial application with the Departments of Health ("Department") and Attorney General ("AG") (collectively, the "Departments") in accordance with the Act. This initial application consists of responses to a series of 73 questions related to, among other issues, the hospitals' financial standing, board composition and governance structure; staffing plans, sale terms and agreement; actions of other state/federal licensing authorities; and provisions for community benefits.¹

On November 18, 2013, the Departments deemed the application incomplete and transmitted a request for additional information. On January 2, 2014, the application was resubmitted with additional materials from the transacting parties.

The initial application was deemed complete and accepted for review on January 16, 2014. The instant proposal is a concurrent review by the Departments, may run up to 120 days in length, and is scheduled to be completed on or about May 16, 2014.

Use of Experts by the Department of Health

Pursuant to the provisions of section 23-17.14-13 of the Act, the Department may engage experts and/or consultants in the review of a conversion application. All cost and expenses accrued in connection with this consulting are the responsibility of the transacting parties, in an amount as determined by the Director of Health.

For this conversion review, the Department contracted with Harborview Consulting, LLC ("Harborview"), the principal of which is John J. Schibler, CPA, Ph.D., to work directly with staff to interpret and analyze financial information supplied by the transacting parties. Additionally, Harborview's services included the analysis of financial documents, papers, and related financial records provided by the transacting parties, that included audited and internal financial and operating statements, and any financial or utilization data provided to the Department by the transacting parties as part of the conversion review. The purpose of the contract was to obtain consulting services of an expert in the hospital/health care accounting industry to develop a financial assessment of the proposed conversion.

The Department also contracted with MRC Consulting LLC, the principal of which is Mary Reich Cooper, MD, JD. The goals for the Department's medical consultant included: (1) work directly with Department staff to provide interpretation and analysis of clinical information as supplied by the transacting parties and as obtained by the Department; (2) analyze all clinical documents, papers and related records; (3) review federal Centers for Medicare and Medicaid Services findings of hospital survey and certification processes, including citations of deficiencies and written plans of correction, and related state surveyor information; (4) ascertain if clinical practices of the transacting parties are in conformity with all applicable standards, statutes and regulations; (5) review quality from the perspective of the Institute of Medicine definition from Crossing the Quality Chasm (2001) with regard to safety, access, patient-centered care, effectiveness, timeliness and efficiency; (6) review population health characteristics of the affected communities and ascertain if plans have been made to address any diseases or conditions that appear to afflict those communities disproportionately; (7) review the service lines and clinical services delivered by the hospitals to ascertain whether adequate resources will continue to be available for those services; (8) review accreditation decisions for hospitals held by the transacting parties and determine if any adverse accreditation reviews have been identified and corrected; (9) review bed availability, staffing, occupancy and maintenance of adequate resources to provide care; (10) review public health indicators for the population served, Community Health Needs Assessments, Community Benefit reports, quality improvement activities, Hospital Compare reports, Meaningful Use certification and HIMSS levels, external grading agency reports and additional external certifications, health plan quality designations such as Centers of Excellence or Centers of Distinction; utilization measures and public citations for fraud and abuse as they pertain to provision of care; and (11) prepare a final written report or presentation related to the foregoing review and analyses.

Confidentiality of Documents

In accordance with section 23-17.14-32 of the Act, the AG maintains jurisdiction over the determination of the confidentiality/propriety of documents submitted by the transacting parties as part of the hospital conversion application review. The statute reads, in part: "The decisions by the Attorney General shall be made prior to any public notice of an initial application or any public review of any information and shall be binding on the Attorney General, the Department of Health, and all experts

or consultants engaged by the Attorney General or the Department of Health.” Confidentiality is often requested by the parties for records that may contain “trade secrets and commercial or financial information which is of a privileged or confidential nature, “tax returns,” “preliminary drafts, notes, impressions, memoranda, working papers, and work products,” and “any records which would not be available by law or rule of court to an opposing party in litigation.”

The transacting parties requested confidentiality for 75 exhibits submitted to the Department along with the application. All or portions of 64 exhibits were subsequently deemed confidential by the AG for purposes of this review on February 28, 2014, in accordance with the request of the transacting parties and all applicable law. Subsequently, certain additional documents (as redacted) were made public by the AG.

Change in Effective Control Review

Pursuant to Chapter 23-17 of the Rhode Island General Laws, as amended, entitled “Licensing of Health Care Facilities,” certain transfers of ownership, assets, membership interest, authority or control of a Rhode Island hospital require prior review by the Health Services Council² and approval by the Department. This review is done in conjunction with the hospital conversion review and is known as the “Change in Effective Control (CEC)” review. The CEC review is a public process that can take up to 90 days. The CEC review criteria are generally similar to, but distinct from, the criteria for a hospital conversion review. The CEC review of Prospect began on February 10, 2014, with a 90-day review commencing on that date.

Transacting Parties

The Act defines the hospitals being acquired as the acquirees. The three transacting parties on the acquiree side are the existing Rhode Island hospitals that are the subject of this application and their parent organization. CharterCARE Health Partners is a tax exempt organization that operates a health care system, which includes Roger Williams Medical Center (“RWMC”) in the City of Providence, and St. Joseph Health Services of Rhode Island (“SJHSRI”), in the Town of North Providence.

CharterCARE Health Partners is the sole member of RWMC, a 220 bed (of which 126 are staffed) acute care community hospital located in Providence, Rhode Island. CharterCARE Health Partners is the Class A member of SJHSRI, which consists of a 359 bed (of which 147 are staffed) acute care community hospital located in North Providence, Rhode Island, known as Our Lady of Fatima Hospital (“Fatima”) and the Center for Health and Human Services clinics in South Providence and Pawtucket, Rhode Island. The Roman Catholic Bishop of Providence is the Class B member of SJHSRI.

RWMC and SJHSRI are the “existing hospitals” for purposes of the Act.

The Act defines the entity acquiring the existing Rhode Island hospitals as the acquirer. The acquirer is Prospect Medical Holdings, Inc. (“PMH”), a Delaware corporation with a principal place of business located in Los Angeles, California.³ PMH is a health care services company that owns and operates 8 acute care and behavioral health hospitals located in California and Texas. These hospitals, all of which are for profit, collectively operate a network of specialty and primary care clinics in addition to their licensed beds. The CEO of PMH is Samuel S. Lee.

The 8 hospitals are owned by four separate companies; 2 in California and 2 in Texas. The 2 California companies are:

(1) Alta Hollywood Hospitals, Inc. ("Alta Hollywood"), which owns and operates three hospitals under a single license: Hollywood Community Hospital of Hollywood (a 100 bed acute care hospital), Hollywood Community Hospital at Brotman Medical Center (an acute care hospital with listed bed capacities ranging from 232 to 420 depending on the source) and Hollywood Community Hospital of Van Nuys (a 59 bed psychiatric hospital); and

(2) Alta Los Angeles Hospitals, Inc. ("Alta L.A."), which owns and operates two hospitals under a single license: the 130 bed Los Angeles Community Hospital and the 50 bed Norwalk Community Hospital.

According to the applicants, these 5 California hospitals have approximately 41,000 annual emergency room visits, approximately 23,500 annual patient admissions, approximately 3200 annual inpatient surgeries and approximately 1500 outpatient surgeries. In general, admissions have trended steadily upward at all of the Prospect California acute care hospitals over the last decade except for Los Angeles Community Hospital. Admissions from the emergency room have been the primary factor as admissions from sources other than the emergency room have trended steadily downward over the period 2006 through 2011 in particular.

The 2 Texas companies are:

(1) Nix Hospitals System, LLC ("Nix"), which owns and operates two hospital facilities in San Antonio, Texas under a single license: Nix Health Care System (a 208 bed acute care hospital) and Nix Specialty Health Center (a 94 bed specialty hospital offering adult behavioral health and detoxification services, an inpatient child and adolescent psychiatric unit and an inpatient physical rehabilitation center); and

(2) Nix Community General Hospital, LLC ("Nix Community"), which owns and operates Nix Community General Hospital (an 18 bed acute care hospital) in Dilley, Texas.

According to the applicants, these 3 Texas hospitals have approximately 7600 annual patient admissions, approximately 1600 annual inpatient surgeries and approximately 3400 outpatient surgeries.

In addition, through its medical group segment, PMH owns and/or manages the provision of physician services to approximately 180,000 HMO members in Southern California through a network of approximately 1100 primary care and 2200 specialty physicians.

Other transacting parties on the acquiring side include the following:

Prospect East Holdings, Inc. ("Prospect East"), a Delaware Corporation, is a wholly owned subsidiary of PMH. Prospect East will hold PMH's interest in Prospect CharterCARE, LLC and its subsidiary hospitals. The CEO of Prospect East is Thomas Reardon.

Prospect East Hospital Advisory Services, LLC (“Prospect Advisory”), a Delaware limited liability company, formed in August 2013, is a wholly owned subsidiary of PMH. Prospect Advisory will manage the day to day operations of Prospect CharterCare LLC. The CEO of Prospect Advisory is Samuel S. Lee.

Prospect CharterCare, LLC, a Rhode Island limited liability company formed in August 2013, will be owned 85% by Prospect East and 15% by CCHP. Prospect CharterCare, LLC will own the entities that will hold the licenses for the new hospitals. It will not itself be a licensed entity. In this regard, it will be similar to the existing CharterCARE Health Partners. The CEO of Prospect CharterCare, LLC will be Kenneth Belcher.

Prospect CharterCare RWMC, LLC (“Newco RWMC”), a Rhode Island limited liability company formed in August 2013, will hold the license for the current Roger Williams Medical Center. New RWMC will be a wholly owned subsidiary of Prospect CharterCARE, LLC. The CEO of Newco RWMC will be Kenneth Belcher. Prospect CharterCARE, SJHSRI, LLC (“Newco Fatima”), a Rhode Island limited liability company formed in August 2013, will hold the license for the current Our Lady of Fatima Hospital. Newco Fatima will be a wholly owned subsidiary of Prospect CharterCARE, LLC. The CEO of Newco Fatima will be Kenneth Belcher.

As a result of the transaction, the existing hospitals (RWMC and SJHSRI) will be converted from non-profit organizations to for-profit organizations (Newco RWMC and Newco SJHSRI).

PMH has a number of non-hospital affiliates which are part of its medical group segment. Although its experience in developing its company from this physician base is an important consideration in the evaluation of this conversion, these non-hospital affiliates are all California-based and have no role or interest in the proposed conversion.

CCHP also has a number of non-hospital affiliates that are important elements of the CharterCARE system but not transacting parties and not relevant to the transaction except to the extent they represent services that are important to be preserved or that otherwise have a role to play in a future integrated system model. They include Elmhurst Extended Care Facilities, Inc., a licensed nursing facility; CharterCARE Home Care, a licensed home nursing care provider; and The Center for Health and Human Services which provides outpatient health care clinical services in South Providence and Pawtucket.

Background

The Providence, Rhode Island Community

U.S. Census data reveal that the population of the city of Providence is 178,432 of the statewide population of 1,050,304.⁴ The CharterCARE hospitals derive the largest number of their admissions from Providence, although these admissions represent only approximately 16% of all Providence admissions. Providence is Rhode Island’s largest city. The median household income for Providence is \$38,243, significantly less than the statewide median income of \$56,102. The median age in Providence is 28.7 years, younger than the statewide median age of 39.4 years. The city has a lower percentage of persons over 65 years than the state average (8.7% compared to 14.4% statewide).

U.S. Census data describe the population of Providence as one that, compared to the rest of Rhode Island, has a lower median income, a higher unemployment rate, a higher percentage of female

households with no husbands present, a higher percentage of children living in families below the federal poverty threshold, a higher teen birth rate, and a markedly different racial mix. This is the largest segment of the population that is served by the CharterCARE hospitals through the St. Joseph Center for Health and Human Services in South Providence and other initiatives undertaken in the community.

Community Health Needs Assessment

In September, 2012, in the culmination of a year- long effort, the SJHSRI and RWMC boards approved Community Benefit and Implementation Plans to address the health needs of their service populations.

SJHSRI identified its service area as incorporating the north end of Providence and the communities of the state generally described as the northwest quadrant, with the exception of Woonsocket. Of these communities, North Providence, Johnston and Smithfield form the real base of the hospital's constituency. These communities, unlike Providence, are suburban and feature a majority of middle to upper middle class households with workers in trade and professional positions. RWMC, for its part, defined its service area as the greater metropolitan Providence area.

The hospitals had conducted community health needs assessments that had identified several key community needs in the service area of the hospitals. Those needs were:

- Mental Health and substance abuse
- Diabetes
- Obesity
- Access to care
- Heart disease
- Cancer (specifically breast and lung)
- Asthma (adult and child)
- Disability (identified by RWMC)

To address these needs, the hospitals identified the following existing resources:

- Inpatient psychiatric and partial hospitalization at SJHSRI
- Inpatient and outpatient substance abuse treatment for alcoholism and drug addiction at RWMC
- A diabetes management center at SJHSRI that is the first in New England to attain Gold Medal recognition from the Joint Commission for diabetes certification
- Affiliated physicians to provide asthma and cardiac diagnostic and treatment services and education concerning obesity and weight loss
- Breast cancer diagnostic, interventional and support group services through the Alice Viola Breast Care Center
- Access to the Roger Williams Cancer Center and the Roger Williams bariatric surgery program
- Bi-lingual translators
- Primary care and specialty clinics for the underserved through the SJHSRI community health center and RWMC's primary care clinics

The following community health outreach initiatives were proposed for adoption in addition to continuation of the programs outlined above:

1. Quarterly free of charge diabetes screening clinics
2. Quarterly free of charge breast care screening clinics
3. Production of collateral material and public service announcements regarding select mental health issues and an awareness campaign on the danger of alcohol abuse
4. Free of charge weight loss seminars
5. Free of charge smoking cessation programs
6. Asthma referral hotline
7. Production of a directory of key health service referral sources

Some among these modest endeavors will be the initiatives selected as most important to the well-being of the communities served by the CharterCARE hospitals within the resources currently available to these institutions.

In contrast, the Prospect hospitals, as for-profit hospitals, have never been required to undertake, and have never undertaken, community health needs assessments or equivalent studies of the health needs experienced by the residents of the communities in which they operate. Nevertheless, they serve core populations in California ranging from 47% to 77% Hispanic, 8% to 10% over age 65, and 44% to 50% at 200% poverty level. Further detail with regard to the demographics of the core populations served by the California Prospect hospitals may be accessed at gis.oshpd.ca.gov

Overview of this transaction

PMH will acquire certain assets of CCHP for \$45 million and thereby acquire an 85% interest in the existing hospitals. CharterCARE Health Partners will retain a 15% interest in the existing hospitals. The \$45 million will be used to retire the long term debt of the existing hospitals (\$31 million) and to increase the funding of the SJHSRI pension plan to greater than 90% (\$14 million). PMH and CharterCARE Health Partners will own Prospect CharterCARE, LLC and will each hold 50% of the seats on the governing board. Prospect CharterCARE, LLC will be a for-profit entity that will own and operate Newco RWMC and Newco Fatima, which will be licensed entities. These entities will be operated by the current CharterCARE Health Partners executive team, which will operate under a management advisory agreement with Prospect East. Each of the new hospitals will have a local board, half of which will consist of physicians on the hospital's medical staff and the other half of which will consist of local community representatives.

In addition to the purchase price, Prospect CharterCARE, LLC proposes to reinvest a minimum of \$10 million per year in routine capital investments at the new hospitals. PMH has also committed to a future contribution of \$50 million within four years of the closing on the transaction. This "long term funding commitment" may include: (a) the development of and implementation of physician engagement strategies and (b) projects related to facilities and equipment, including but not limited to : 1) expansion of the cancer center at Newco RWMC, 2) expansion of the emergency department at Newco RWMC, 3) renovation/reconfiguration of the emergency department at Newco Fatima, 4) renovation of the operating rooms at Newco RWMC, 5) conversion of all patient rooms to private rooms at both new hospitals, 6) renovation and expansion of the ambulatory care center at Newco Fatima, 7) new windows at both new hospitals, 8) a new generator at Newco Fatima, 9) a renovation to the facades at both new hospitals.

Whether the long term funding commitment is spent on physician engagement strategies or one or more of the listed capital projects will depend on the results of studies and analyses to be undertaken after the conversion is approved.

PMH has also pledged to maintain all existing services at the new hospitals for a period of five years post-transaction.⁵

The parties also pledge to undertake strategic initiatives in order to develop a coordinated care platform which collaborates with other providers and community-based health care entities to provide population management under risk contracts. Some of these initiatives could encompass the growth and development of clinical centers of excellence, clinical integration and medical staff-system alignment and engagement.

The parties have pledged to preserve existing jobs post-conversion. Existing employees will be offered employment by Prospect CharterCARE, LLC at base salaries and wages equal to the base salaries and wages they had received as employees of the existing hospitals. The retained employees will also retain their seniority for purposes of benefits, salaries and wages and will receive benefits comparable to those they had received under the plans of the existing hospitals.

Statutory Review Criteria Considered by the Department

Sections 23-17.14-8 and 23-17.14-28(a) of the Act set forth the review criteria as follows: "In reviewing an application for a conversion involving hospitals in which one or more of the transacting parties is a for-profit corporation as the acquirer, the department shall consider the following criteria:

- 1) Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties, are satisfactory;
- 2) Whether sufficient safeguards are included to assure the affected community continued access to affordable care;
- 3) Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;
- 4) Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;
- 5) Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;
- 6) Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;
- 7) Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state"
- 8) "For any conversion subject to this chapter, the director . . . shall consider issues of market share especially as they affect quality, access, and affordability of services."

A discussion of these review criteria and the Director's findings appear below.

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

Discussion

The Department interprets this criterion to mean that patient care is delivered by the transacting parties in a manner that merits the public trust; that the transacting parties' methods of delivering patient care do not jeopardize the health, safety and well-being of the patients they serve; that there is no pattern of conduct, behavior, or inaction of the transacting parties that impedes the health, safety, and well-being of their patients; and that the mission and goals of the parties are focused upon patient care-giving and fostering the public trust.

"Character" of the transacting parties may be demonstrated by their corporate integrity, transparency of decision-making, and their emphasis on remaining inclusive in a dynamic healthcare marketplace. *"Commitment"* may be demonstrated by the extent to which the transacting parties provide care that improves measurable health outcomes for the entire population in the geography served by the entities. *"Competence"* may be demonstrated by organizations that are committed to decisiveness, leadership, creativity, community and situational awareness, and are disciplined enough to achieve their stated goals in a financially prudent manner. *"Standing in the community"* may be demonstrated by the respect that local/state governments and community-based organizations have for the hospital.

The Department considered the following proxies for this criterion:

- Regulatory status, including any adverse licensure actions;
- Accreditation status of the transacting parties;
- Patient satisfaction survey results and other information compiled by the federal Centers for Medicare and Medicaid Services;
- Quality improvement initiatives;
- Financial stability of the acquirer; and
- Standing in the community.

PMH History

PMH effectively commenced operations in 1996 and over the course of the next decade acquired fourteen physician organizations in Southern California that provided PMH with a substantial concentration of HMO enrollees. In 2005, PMH acquired a minority interest in its first hospital, Brotman Medical Center. In 2007, it acquired a management company and two other physician organizations that added an additional 80,000 HMO enrollees and acquired the four hospitals owned by Alta. Beginning in 2009, PMH increased its ownership interest in Brotman Medical Center to majority status, acquiring full ownership in 2012. PMH only acquired its Texas hospitals in 2012 and 2013.

In the California market where it had developed physician networks as a first order of priority, it sought to generate organic growth primarily through cross-fertilization between its medical group and hospital service segments.

In this regard, it used its community hospitals to facilitate growth to Brotman; it used its medical group enrollment to drive business to its hospital facilities; it leveraged its medical groups to enhance payor diversification for its hospitals; and it expanded HMO contracts by offering a combined hospital-physician provider solution.

Within the hospitals themselves, PMH monitors cost trends, operating performance and the regulatory environment in order to drive operating efficiencies, such as the optimization of staffing and utilization levels. Its operating model is physician-centric. It strives to provide convenience in scheduling and collaborative patient care management in order to assist in the treatment of the patient and in the physicians' time management.

With respect to the Brotman Medical Center, in particular, in addition to driving operating efficiencies, PMH added new payors, improved reimbursement from existing payors and recruited new physicians to the medical staff.

PMH has targeted "underperforming hospitals struggling with inefficient operations and high cost structures" and the assumption here, at least when the SJHSRI cost structure is taken into account as well as the manner of purchase in reducing long term debt and pension obligations, is that CCHP fits PMH's definition. PMH's philosophy is to offer a cost-efficient community hospital alternative to the tertiary care hospitals in competitive markets.

Its challenge in Rhode Island will be to achieve, consistent with the maintenance of quality, a degree of cost efficiency sufficient to enable consumers, payors and physicians to see the economic benefits of utilizing the CCHP hospitals where feasible rather than tertiary hospitals competing for the same service populations.

Whether PMH can be as successful in this market without the advantage of developed physician organizations preceding its hospital acquisition is unknown.

Licensure

All of the hospitals on both sides of the transaction are licensed and in good standing in their respective jurisdictions.

Accreditation

The report of the Department's quality consultant is attached as Appendix A. The quality consultant noted that RWMC and SJHSRI are both accredited by the Joint Commission ("JC"), while the five Prospect California hospitals and NIX Health Care System are accredited by Det Norske Veritas ("DNV") and NIX Community Hospital is accredited by the JC.

RWMC and SJHSRI also hold special JC accreditations for Advanced Primary Stroke, Hip Replacement, and Knee Replacement; while SJHSRI also holds one for Advanced Inpatient Diabetes. Roger Williams also holds a special quality award for stroke. (Get with the Guidelines Silver Achievement Award from the American Heart Association.)

Although the Prospect hospitals do not seek out such special separate accreditations for services at their California or Texas facilities, Prospect has pledged to continue the special accreditation programs at Newco RWMC and Newco Fatima.

Quality Awards-Prospect

In 2012 PMH's Texas hospitals were recognized as Top Performers on Key Quality Measures by the JC and Nix Community General Hospital earned the JC's Gold Seal of Approval. PMH's Texas hospitals also have been recognized by the JC for Excellence in Surgical Care Improvement Measures. The hospital systems of PMH in Texas are ranked by CareChex among the top 15% of hospitals nationwide in overall patient care and received the Get with the Guidelines Gold Achievement Award from the American Heart Association

According to the California Healthcare Foundation, PMH's California hospitals received superior ranking in quality of care for heart attack clinical measures, heart failure clinical measures, and pneumonia clinical measures. These hospitals also received superior ranking in mortality for pneumonia and acute stroke.

According to Healthgrades, Los Angeles Community Hospital received 5-star ratings on 14 clinical measures, including Pulmonary Care Excellence in 2013 and 2014, Stroke Care Excellence in 2012, 2013, and 2014, Gastrointestinal Surgical Excellence in 2013, and Maternity Care Excellence in 2011. Hollywood Community Hospital received 5-star ratings on 5 clinical measures, including Pulmonary Care Excellence in 2012, 2013 and 2014. Brotman Medical Center received 5-star ratings on 3 clinical measures, including Gastrointestinal Surgical Excellence in 2010.

Prospect Medical Group and ProMed Health Care Administrators received Elite Status from the California Association of Physician Groups' Standards of Excellence Program in 2012 and 2013. The physician groups received a Certificate of Outstanding Performance from the Integrated Healthcare Association.

Quality Measures

The quality consultant also benchmarked federal measures of outcomes, patient satisfaction, efficiency and safety against the Commonwealth Fund's, "Why Not The Best?" benchmarking information. This information was derived from CMS Hospital Compare data through March 2013.

In the area of quality outcomes, the quality consultant focused on the outcome measures for overall recommended care, heart attack, heart failure, pneumonia and surgical care. For the year ended March 2013, RWMC was at the national average and slightly above the Rhode Island average for overall care. It was below the national and RI average for heart attack care, slightly below the national and RI averages for heart failure care and pneumonia, and above the national and RI averages for surgical care, with trending improvement for all but heart attack care over the period April 2010 through March 2013.

For the year ended March 2013, SJHSRI was above the national average for heart failure and surgical care and slightly below for the other three measures. It was above the RI averages for heart attack and heart attack care and slightly below the state averages for the other three. Here again, SJHSRI showed improvement for all measures since March 2010 except for heart attack care.

For the only year of relevance (given Prospect's relatively recent acquisition of the NIX Health Care System), NIX was above the national and Texas averages for surgical care but below both for heart failure and pneumonia care.

Among California's Prospect hospitals, the Alta Hollywood hospitals were above national and California averages for surgical care but below both for the remaining four measures. There was significant improvement from 2010 in the measures for heart failure and pneumonia. (The numbers for Brotman Medical Center were particularly good for all measures, beating both national and California averages except for surgical care where the hospital fell slightly behind the national and California averages.)

The Alta L.A. hospitals eclipsed the national and California averages for heart failure and pneumonia care but were behind both national and California averages for the other three measures. All five hospitals showed marked improvement from April 2010 to March 2013 with a particularly significant increase occurring during the period from April 2012 to March 2013.

Mortality Rates (July 09-June 12)

The quality consultant compared 30 day mortality rates for three conditions: heart failure, heart attack and pneumonia as well as Medicare 30 day mortality rates for heart failure. Although it is difficult to draw conclusions from the data without further in depth study of factors such as patient mix, in general, the Prospect hospitals all had lower 30 day mortality rates for the observed conditions than did the two Rhode Island hospitals. Of the latter, the SJHSRI 30 day mortality rates exceeded the national rates for all four conditions and the Rhode Island rates for all but heart failure. Roger Williams, for its part, beat the national and RI averages for all but heart attack.

Patient Satisfaction

The quality consultant looked at ten measures of patient experience. In evaluating these statistics, California averages are generally lower than national averages, Texas averages are generally higher than national averages, and Rhode Island averages trend slightly below or slightly ahead of national averages for half of the measures in each case. As these measures are far more subjective, the best that can be said is that the patient experience at Roger Williams has been generally stable since March of 2010 while that at SJHSRI has shown improvement across most measures. The NIX Health Care System patient experience has been stable with scores generally comparable to or slightly higher than scores experienced by the Rhode Island facilities. By contrast, the Prospect California hospitals have generally low scores and will be unlikely to serve as models for the Rhode Island hospitals in this area.

Readmission Rates

As was done for mortality, the consultant measured Medicare 30 day readmission rates for heart failure as well as rates of 30 day readmissions for heart attack, heart failure and pneumonia patients. This measure has received more recent publicity since Medicare and other insurers will be penalizing hospitals that fail to achieve targets for readmission. The rates for readmission cited are generally highest for SJHSRI, followed by a close mix for the Prospect California hospitals, the national statistics, and the Prospect Texas hospitals, with RWMC, with the exception of heart failure patients, having the best readmission rates among the comparison group.

Patient Safety

All of the hospitals whether in Rhode Island, in California or in Texas participate in reporting to patient safety organizations.

Conclusion

After review of these various quality indicators and in the absence of any reported licensure or accreditation deficiencies or public citations for fraud and abuse, the quality consultant concluded that the transacting parties satisfied all the requirements identified in the Act with respect to quality issues.

Financial Stability of the Acquirer

The report of the Department's financial expert is included at Appendix B.

According to the financial expert, Prospect has adequate financial resources to fund the joint venture. It will do so through existing cash and an available line of credit.

An analysis of Prospect's financial statements indicates that historical income from operations has been positive. As examples:

- EBITDA, Earnings Before Interest, Taxes, Depreciation and Amortization over the past four years (2010-2013) has ranged between 8.9% and 13.8%, indicating the ability to service existing debt and make routine and strategic investments.
- As compared to similar publicly traded companies, various performance ratios suggest that Prospect compares favorably as to return on assets and overall balance sheet liquidity.
- Leverage ratios are generally higher than similar publicly traded companies, suggesting higher risk; such higher leverage would be expected of growth companies.

With respect to internal controls, while conducting the CharterCARE/Prospect analysis, nothing came to the attention of the financial expert that would indicate any significant weakness in internal controls through his examination of management letters issued by each organization's respective independent auditors.

In concluding his review, the financial expert concluded "nothing has come to my attention that the transaction should not be approved."

Community Standing

The Department received letters of support from the community related to this hospital conversion application from the following: the Lutheran Family Health Centers, the Cardiovascular Institute of New England, the Bishop of the Roman Catholic Diocese of Providence, the Elmwood Neighborhood Association, Consultants in Urology, Inc., the Southside Community Land Trust and the United Nurses and Allied Professionals. In addition, several letters were filed in opposition by Prime Healthcare Services to which the applicants responded.

A joint public informational meeting, sponsored by the Departments of Health and the Attorney General, was convened on Monday, April 28, 2014 from 4:00 – 7:00 p.m. at the Gaige Auditorium, Rhode Island College, 600 Fruit Hill Avenue, Providence, Rhode Island on the matter. Over 25 persons presented testimony. Two of the presenters expressed concern with respect to the preservation of Catholic principles at Fatima. Representatives of Prime Health Care Services, Inc. spoke against the transaction. Prime objected that the Board of CCHP was not made aware of Prime's revised proposal before selecting Prospect.⁶

Finding:

During the six years of Prospect's ownership of hospitals, the record suggests that it has been successful in operating hospitals that have had financial difficulties in the past and has delivered uncompensated care to underserved populations in the communities served by its hospitals. Prospect understands the importance of medical staff-system alignment and engagement. The Department's quality and financial experts viewed Prospect as exhibiting competence in the area of quality and financial management. The existing hospitals enjoy a good reputation for delivery of quality care and for service to the underserved. On the basis of these factors, Prospect is deemed to meet the requirements of this criterion.

#2: Whether sufficient safeguards are included to assure the affected community continued access to affordable care

Discussion

The Department interprets this criterion in light of the health care delivery system that is currently in place in the affected community and the commitments that the acquirer has made to the community in facilitating continued access to affordable care in the CharterCARE service area. In addition, the consideration of this, as with all criteria, is not taken in isolation; rather, the Department informs its consideration by being mindful of its charge to further the purposes of the Act, including to “[a]ssure the viability of a safe, accessible and affordable healthcare system that is available to all of the citizens of the state[.]” RIGL 23-17.14-3(1)

Accordingly, this review takes cognizance of the findings of the Health Care Planning & Accountability Advisory Council’s (HCPAC) April 2013 Report to the General Assembly as they relate to an affordable healthcare system for all Rhode Islanders and not only within the affected community: that the most likely forecast of hospital inpatient beds for 2017 is “an excess of approximately 200 staffed beds,” and that savings associated with eliminating excess inpatient capacity in the most likely scenario range from about \$12 million, when only incremental costs are considered to more than \$100 million when all hospital costs are eliminated.” (Report page 4)

Since affordability is a significant factor in access to hospital care, and given these findings of the HCPAC, the positive impacts of maintaining a hospital for the affected community must be balanced against the possible negative statewide impacts. Prospect’s business model and record do not provide any indication that it will improve hospital care affordability in its service area. As PMH asserts on its website:

“We operate both our hospitals and Medical Groups by applying highly disciplined data-driven management to the provision of quality care. Through this in-depth and data-driven approach to analysis and application of various operational and financial metrics, we have been able to achieve a highly efficient cost structure which enables us to adjust our operations to provide services that generate higher margins and revenue growth. Our management’s expertise in executing our operating model has enabled us to increase profitability across a diverse mix of payors and the flexibility to adapt to economic and regulatory changes. Our operating model also allows us to be well positioned for the future, as we believe that the most cost-efficient providers will be the ones who benefit in the rapidly changing economic and regulatory environment.”

Thus, Prospect will not be seeking to provide essential but under-reimbursed services to its service population but will be looking for services that generate higher margins and revenue growth. This is not to suggest that the Department is critical of the business model but merely that the business model must be evaluated with regard to its impact on affordable care statewide. In that context, the Department must consider whether one or both hospitals should be maintained long term in light of the needs of their service population –a circumscribed one that has not demonstrated the volume necessary to support the long term existence of both hospitals.

In 2009, RWMC and SJHSRI went through the conversion process in order to stem significant annual combined operating losses. CharterCARE was formed in 2010. Although efficiencies of more than

\$10 million were achieved through the end of FY 2010 and an additional \$12 million were identified in 2011, the combined system still lost \$11 million from operations in FY 2011. Accordingly, in December 2011, CharterCARE issued a Request for Proposals ("RFP") seeking a partner. In August of 2012, PMH submitted a response to the RFP. After several months of negotiation, a final proposal was presented to the boards of CharterCARE and its constituent hospitals at a joint meeting in March of 2013. Upon approval, a letter of intent was executed followed by an asset purchase agreement which incorporated the elements summarized in the overview of the transaction.

In that regard, Prospect has now promised to do for the existing hospitals and their service populations what CharterCARE had hoped to do in 2009. As noted in the Department's report in 2009, "A major safeguard to assure access to affordable care is the continued availability of a strong system of community-based hospitals to serve as an appropriate first choice for care that can be delivered safely and most appropriately by such organizations." The Department believed that the affiliation of RWMC and SJHSRI, as community-based hospitals, would improve their ability to negotiate payment rates that would support them financially. In the Department's view, this would assure their continued existence and their ability to provide safe, high quality care and would enable them to compete more effectively with larger hospital systems.

There was a caveat to that analysis, however. As the Department noted, the experience of past affiliations had shown that the closer the affiliation was to a total consolidation of hospitals, the more efficiencies and cost savings resulted, citing studies that reported that combinations in which hospitals operated under a single license generated substantial savings, while system formation in which hospitals retained their individual licenses did not.⁷ The experience of CharterCARE during the two years of its existence seems to have validated this conclusion. Although the hospitals achieved efficiencies of \$3.5 million in FY2012 and reduced combined losses to \$3 million for FY 2012, unaudited financials for FY 2013 indicate that losses from hospital operations in FY 2013 had climbed to \$4.8 million and are projected to exceed \$7 million in FY 2014. The 2009 financial projections had assumed that the hospitals would maintain or increase patient service volume. This, they have been unable to accomplish. As the Department's consultants noted in 2009, if the actual revenue stream ended up being less than projected, not only would it be necessary to continue to implement the planned savings initiatives to maintain a positive bottom line, but it would also be critical for the two hospitals to quickly implement contingency plans that would have to encompass some type of clinical consolidation in order to achieve additional cost saving initiatives.

However, in 2009, neither hospital planned to eliminate any clinical programs or services that were duplicative across the two hospitals. The hospitals stated that clinical consolidation would be limited to coordination and collaboration and that they did not anticipate clinical service integration until three to five years beyond the initial affiliation. Not surprisingly, the hospitals are before the Department even sooner than anticipated. Moreover, with the exception that the acquirer has access to capital that CharterCARE did not have, and had no prospects of attaining, the hospitals are again before the Department with a largely unchanged game plan. RWMC and SJHSRI continue to serve similar communities, with a number of patients at both hospitals primarily coming from Providence and North Providence, and a lesser volume of patients coming from surrounding communities and several outlying communities in the East Bay area. As was the case in 2009, Prospect, subject to certain conditions, is not planning to eliminate or significantly reduce any services RWMC and SJHSRI currently provide to their community. Given the fact that admissions are trending down at both hospitals and that the market share of the hospitals appears to be shrinking rather than increasing, it is difficult to see how the

hospitals can survive or the system can be made more affordable without service consolidations initiated in the very near term.

The important points in the hospitals' favor in 2009 remain the important points in the hospitals' favor currently. Both SJHSRI and RWMC provide primary care services in medically underserved areas. SJHSRI has historically supported a major primary and specialty care health center in a very low-income neighborhood in Providence's south side. Prospect has asserted its continuing commitment to this health center, and the services offered through it.

Similarly, RWMC offers primary care and internal medicine services through its medical residency program, affiliated with the Boston University School of Medicine. Patients are seen one afternoon each week at a site on the RWMC campus by RWMC resident physicians, who provide care for the same patients for three years. A faculty of academic general internists supervises this service.

Whether preservation of these key services and of the psychiatric and substance abuse detoxification services these institutions provide on the inpatient side is sufficient to justify maintaining the two hospitals as they have been maintained for at least the last four years is the crucial question. While losses have been stemmed to a certain extent, the financial situation for CCHP, and particularly at SJHSRI, continues to be weak and will continue to be so even with elimination of the hospitals' long term debt and the stabilization of the SJHSRI pension fund. The applicants themselves project a combined daily census in 2016 that is only about 5% higher than that which they experienced in 2013. In the Department's view, the effort to maintain an underutilized bed supply and two full service campuses within two and one half miles of each other will likely doom the venture's sustainability once again, regardless of the investments to be made.

As noted in the December 19, 2012, Xerox report, "Variation in Payment for Hospital Care in Rhode Island," prepared for the Rhode Island Office of the Health Insurance Commissioner and the Rhode Island Executive Office of Health and Human Services, SJHSRI was a relatively high cost hospital and RWMC was at the low end of relative cost levels across the hospitals in Rhode Island. SJHSRI was also rather unique in that its outpatient cost structure appeared to be low while its inpatient cost structure was quite high. This high cost anomaly may present Prospect with significant opportunities to achieve efficiencies beyond those that were achieved during the CharterCARE years.

The Department continues to believe that a number of services provided by these two hospitals are critical to their immediately surrounding communities and would have to be preserved even in the absence of the hospitals. It is those services that Prospect will be required to preserve so long as it continues to have a majority interest in the joint venture between PMH and CCHP.

Finding:

Assuming Prospect complies with the requirements contained in this Decision to preserve those services viewed as essential by the Department for as long as Prospect remains the controlling interest of the joint venture the transacting parties will be deemed to have satisfactorily met the requirements described in criterion #2.

#3: Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community

Discussion

The Department interprets this criterion in light of the historical role that Rhode Island hospitals have played in their communities. Hospitals are institutions that remain the “safety net” providers for many who are sick, vulnerable, and lack access to health care.

Traditionally “underserved communities” are often defined in terms of income level, educational achievement, employment status, insurance status, race, culture, disabilities, and families with children living below the federal poverty level.

There are several “safety net” providers in the CharterCARE service area, including Tri Town Community Health Center, located in Johnston, WellOne Primary Medical and Dental, which has a site in Foster, and the Providence Community Health Centers, particularly the Chad Brown, Capitol Hill, Olneyville and Central sites. These are all part of a system of nine federally-funded community health centers throughout Rhode Island that are committed to providing a well-trained, culturally-competent, diverse clinical work force for treating Rhode Island’s medically underserved population. In addition, the Providence Center and Gateway provide behavioral health services to residents of CharterCARE’s primary communities.

As noted in 2009 and again in the context of this review, the existing hospitals themselves have histories of providing care to the underserved. For example, SJHSRI operates adult and geriatric psychiatric inpatient units, as well as an outpatient psychiatric service that are critical components of Rhode Island’s behavioral health care delivery system. St. Joseph’s Health Center is located in the heart of Providence’s inner city, providing 58,000 patient visits annually. The health center includes a walk-in clinic that provides a more appropriate and cost effective alternative to emergency department use for non-emergent urgent care needs. The health center also provides primary care to a low income, multicultural, traditionally underserved population. In addition to pediatric care, adult primary care, women’s health care, and chronic disease clinics, St Joseph Health Center has a number of unique services that are not replicated elsewhere in the state. It operates the only pediatric dental residency program in the state, graduating four pediatric dentists each year in partnership with Lutheran Medical Center’s Dental School in Brooklyn, NY. The pediatric dental clinic provides critical dental services to thousands of underserved children. In addition, St. Joseph Health Services operates a lead clinic, a unique service providing comprehensive care and treatment to children who have been diagnosed with lead poisoning.

RWMC also provides critical services not available elsewhere in the state. It operates the state’s only inpatient detoxification unit. This Level 4 unit has the expertise and capacity to provide drug and alcohol detoxification for the most clinically complex cases.

RWMC also has a gerontology program that offers a broad continuum of hospital and community –based geriatric services provided by geriatricians in partnership with other primary care physicians, resident physicians, psychiatrists, other physician specialists, nurses, physical therapists, occupational therapists, speech therapists and other caregivers. RWMC has an extensive network to provide for seniors’ medical needs from the hospital to home, including critical care, intensive care,

specialized inpatient geri-psychiatric care for seniors with mental illness, sub-acute care, skilled nursing facility care (through the only nursing home in Rhode Island affiliated with a hospital), home care services, and care in senior living and senior activity locations.

In addition to requiring that the new hospitals continue to provide these services, the Department expects close collaboration between the hospitals and the earlier listed providers of primary care in order to assure coherent and coordinated patient care, to assure the best health outcomes from medical services provided to the community, to minimize the need for unnecessary hospital services, and to prevent unnecessary readmission after a patient's hospital stay.

The Department also considered the following proxy related to this criterion:

- Charity care trends of the transacting parties.

Charity Care

Section 11.0 of the Department's *Rules and Regulations Pertaining to Hospital Conversions* requires Rhode Island-licensed hospitals to provide charity care, uncompensated care, and community benefits to eligible patients. Hospitals are required to provide "full charity care" (defined as 100% discounted service for patients whose annual family income is up to and including 200% of the federal poverty level). "Partial charity care" (defined as discounted service covered at less than 100% for patients whose annual family income is between 200% and 300% of the federal poverty level) must also be provided by Rhode Island-licensed hospitals.⁸

Hospitals may not discourage patients who cannot afford to pay from seeking essential medical services or direct them to seek such services from other providers. Hospitals must prominently display notices in emergency departments, admissions areas, outpatient care areas, hospital websites, and on patients' bills that inform patients that they may be eligible for free or discounted care.

The implementation of the Patient Protection and Affordable Care Act of 2010 may result in a decrease in charity care expenses for hospitals, as more consumers purchase affordable insurance on health insurance exchanges or become eligible for health care coverage through public programs, such as the expansion of Medicaid. Depending on the cost sharing levels expected of the consumers, there is also an expectation that the demand for hospital services will increase after January 1, 2014, when persons who previously deferred the utilization of health care due to a lack of insurance coverage begin to seek care. This may or may not be accompanied by higher levels of bad debt as consumers struggle to deal with the higher levels of cost-sharing they may have chosen. In any event, it is not anticipated that the levels of uncompensated care provided by the existing hospitals will diminish in the short term.

Between 2010 – 2012, Prospect's hospitals (all of which are for profit) provided approximately \$60 million annually in charity/uncompensated care (at charges) as shown below:

Los Angeles Community Hospital and Norwalk Community Hospital

2010	\$22,458,340
2011	\$21,226,916
2012	\$21,500,000 (est.)

Hollywood Community Hospital and Hollywood Community Hospital of Van Nuys

2010	\$ 8,000,014
2011	\$11,163,930
2012	\$10,700,000 (est.)

Hollywood Community Hospital at Brotman Medical Center

2010	\$22,680,844
2011	\$30,071,451
2012	\$24,119,275

Nix Health Care System, Nix Specialty Health Center, Nix Community General Hospital

2010	\$4,394,552
2011	\$4,810,419
Jan. 2012	\$ 405,592
Feb.-Sept. 2012	\$5,066,282 (under Prospect ownership)

This history of uncompensated care at the Prospect hospitals suggests continuation of charity care levels at the new hospitals should not be a problem. Historical uncompensated care levels at the existing hospitals are as follows, also at charges:

RWMC

	Bad Debt	Charity Care	Total
2010	\$8,572,170	\$7,858,539	\$16,430,709
2011	\$7,317,718	\$8,494,862	\$15,812,579
2012	\$7,347,021	\$11,167,115	\$18,514,135

SJHSRI

2010	\$10,741,393	\$7,438,213	\$18,179,606
2011	\$9,241,436	\$11,115,843	\$20,357,379
2012	\$9,477,814	\$14,934,326	\$24,412,140

Prospect has committed to assure continued delivery of uncompensated care at the new hospitals consistent with historical experience and in accordance with state and federal requirements.

The Department also believes that, notwithstanding the for-profit nature of the new hospitals going forward, the new hospitals should continue to prepare community health needs assessments, designed in collaboration with the Department, focused on the health needs of the residents of North Providence, Johnson, Smithfield, Foster, Gloucester, and Scituate, and implemented in response to these needs with a goal of optimizing health outcomes for the target populations.

Finding :

Based upon the discussion above, the transacting parties will be deemed to have satisfactorily met the requirements described in criterion #3, if they preserve the psychiatric, substance abuse, and health center services discussed above and if they continue to provide uncompensated care consistent with historical levels. If the conversion is approved, there will be a need to ensure closer collaboration between the transacting parties and the community health centers serving the CharterCARE communities.

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

Discussion

The Department interprets this criterion as it relates to the Medicare Anti-Kickback Statute, Section 1128B of the Social Security Act, and the Physician Self-Referral (“Stark”) Law, Section 1877 of the Social Security Act.⁹ Stark applies to hospitals that participate in Medicare and Medicaid and their affiliated physicians. Stark may be broadly interpreted to mean that, in the absence of an exception, “...a physician may not refer a patient for certain services to be reimbursed by federal healthcare programs to an entity with which the physician has an ownership interest or compensation arrangement.”

The Medicare Anti-Kickback statute also applies to hospitals that participate in Medicare and Medicaid. This statute also governs hospital – physician financial relationships, among others. Broadly, unless a safe harbor applies, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., “remuneration”) in return for a referral or to induce generation of business reimbursable under a federal health care program.” Violations of these statutes can result in fines, imprisonment, and exclusion from participation in government-funded health care programs.

The Department considered the following proxies related to this criterion:

- Codes of conduct and corporate compliance documents; and
- Compliance with the federal Stark and Anti-Kickback statutes.

Prospect has no history of violations, or investigations regarding potential violations, of the Stark or Anti-Kickback laws. Prospect submitted its corporate code of conduct and conflict of interest policies to the Department as part of this review. This code applies to all Prospect personnel.

In summary, there is no evidence to suggest that ownership interests can or will be used as an incentive for hospital employees or physicians to refer patients to the new hospitals.

Finding:

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in criterion #4.

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

Discussion

The Department considered the following proxy for this criterion:

- Presence of collective bargaining agreements at the new hospitals.

There are no collective bargaining agreements at RWMC. In its hospital conversion application materials, the transacting parties submitted a memorandum of agreement, executed in June 2013, between SJHSRI and the Federation of Nurses and Allied Health Professionals, Local 5022 which was extended to April 30, 2014, as well as an agreement between SJHSRI and United Nurses and Allied Professionals, Local 5110 dated November 2008 which was extended to July 31, 2014. Prospect has agreed to assume the provisions of the latter and has agreed to the terms of a successor agreement, the term of which runs from August 1, 2014 through July 31, 2015.

The United Nurses and Allied Professionals submitted a letter in support of this transaction noting, "The partnership that has been successfully forged between Prospect and the UNAP will ensure that Prospect will continue to be able to retain and recruit skilled and experienced nurses. That, in turn, will go a long way in ensuring the success of the proposed joint venture. As such, the UNAP fully supports the pending application."

Finding:

Based upon the discussion above, the transacting parties are deemed to have satisfactorily met the requirements described in #5.

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

Discussion

The Department interprets this criterion in light of the transacting parties' commitments to provide sufficient and appropriate staffing at the new hospitals and to address workforce retraining, as needed.

The Department considered the following proxy related to this criterion:

- Workforce retraining policies, as well as any demonstrated initiatives related to employee re-training.

Prospect has indicated that it intends to retain all of the existing hospital employees post-conversion. Prospect expects that current staffing levels will not materially change. In that context, workforce retraining is not a major element of the application.

However, according to the application, for FY 2013, CharterCARE employed 2276 full-time equivalents (FTEs) for a total payroll expense (with fringe benefits) of \$186,350,613.

By FY 2016, CharterCARE projects employment of 2304 FTEs for a total payroll expense (with fringe benefits) of \$201,854,643. This presumes the preservation of all services at both hospitals.

As noted at various points in this decision, the Department does not believe preservation of all services at both hospitals is either essential or consistent with an affordable system. Accordingly, Prospect is encouraged to develop a workforce retraining program in the context of the probability of FTE reductions within the first three years after conversion.

Finding :

Based upon the discussion above, the transacting parties are deemed to have overstated the employment needs at the new hospitals and, in that context, if this conversion is approved, will be required to submit a workforce retraining program within 6 months after such approval.

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

Discussion

The Department views this criterion as a representative summary of the statutory criteria, and related issues, in determining if the public interest will be served by approving the affiliation of RWMC and SJHSRI with Prospect. The Department's interpretation of key statutory terms cited in criterion #7 (above) are discussed below.

Balanced Healthcare Delivery System

A "balanced" health care delivery system could be characterized as one that provides an optimal mix of primary and specialty services within a defined geographical area. Such a system would enable patients to receive care in their own communities and would include key ingredients, such as home health care services. A balanced delivery system would also provide the most appropriate patient care services, in the least restrictive setting, for the most cost-effective price.

Essential Medical Services and Public Interest

The Department interprets this criterion in light of its definition of "essential" medical services as, "hospital services that are reasonably required to diagnosis (*sic*), correct, cure, alleviate, or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the person requesting the service" (emphasis added).

The CharterCARE hospitals are separated in distance by 2.5 miles. Of the services they offer, only the following are not duplicated at both locations: diagnostic cardiac catheterization, blood and marrow transplantation, surgical and radiation oncology, sleep lab, dermatology, homecare, inpatient rehabilitation services, inpatient addiction medicine services, hyperbaric services and health center services (at SJHSRI). In this context, the services that RWMC and SJHSRI provide are essential but with the exception of the above listed services, they are duplicated not only between both locations but also at a number of hospitals within a 5 to 10 mile radius.

CharterCARE: Selected Utilization Data

In considering essential medical services in the CharterCARE service area, it is informative to review selected utilization data for the CharterCARE service population as reported to the Department. That population derives from certain communities (Johnston, North Providence, Smithfield, Cranston, Bristol, Warren, and parts of Providence and Scituate) none of which utilizes the CharterCARE hospitals as the site for 50% or more of their hospitalizations. Among these communities, Johnston, North Providence and Providence are the primary ones to consider.

Inpatient Hospitalizations of Johnston Residents

During 2011, of the 2912 hospitalizations among Johnston residents, 652 (22.4%) were at SJHSRI and 366 (12.6%) were at RWMC. For the same period, 946 residents (32.5%) were hospitalized at Rhode Island Hospital or Miriam while 500 (17.7%) were hospitalized at Women & Infants. Together, these represent approximately (85%) of all hospitalizations among Johnston residents.

Among the 1018 Johnston resident hospitalizations at CharterCARE hospitals, 33 (3.2%) were uninsured, slightly less than the 3.7% uninsured of all Johnston hospitalizations.

Emergency Department (ED) Visits by Johnston Residents

During 2011, of the 5114 ED visits by Johnston residents, 1439 (28.1%) were at SJHSRI and 545 (10.7%) were at RWMC. Comparable statistics for Rhode Island Hospital, Hasbro and Miriam were 2210 (45.2%). Together these represent nearly 85% of all ED visits by Johnston residents.

Among the 1984 Johnston resident ED visits to the CharterCARE hospitals, 243 (12.2%) were uninsured. Of the 5114 Johnston residents who visited any ED in Rhode Island during 2011, 754 (14.7%) were uninsured.

Inpatient Hospitalizations of North Providence Residents

During 2011, of the 3319 hospitalizations among North Providence residents, 942 were at SJHSRI (28.4%) and 296 were at RWMC (8.9%). For the same period, 1023 residents (30.8%) were hospitalized at Rhode Island Hospital or Miriam and an additional 627 residents (18.9%) were hospitalized at Women & Infants Hospital. Together, these represent more than 85% of all hospitalizations from North Providence. Among the 1238 North Providence resident hospitalizations at CharterCARE hospitals, 48 or 3.8% were uninsured, slightly less than the 4.2% of all North Providence hospitalizations that were uninsured.

Emergency Department (ED) Visits Among North Providence Residents

During 2011, of the 6743 ED visits by North Providence residents, 2824 (41.9%) were at SJHSRI and 425 (6.3%) were at RWMC. Comparable statistics for Miriam, Hasbro and Rhode Island Hospital were 2616 (38.8%). Together, these represent over 85% of all ED visits by North Providence residents.

Among the 3249 North Providence ED visits at CharterCARE hospitals, 406 (12.5%) were uninsured. Of the 6743 North Providence residents who visited any ED in Rhode Island during 2011, 1033 (15.3%) were uninsured.

Inpatient Hospitalizations of Providence Residents

During 2011, of the 16,027 hospitalizations of Providence residents, only 1553 (9.7%) were hospitalized at RWMC and 999 (6.2%) at SJHSRI. By comparison, fully 31.9% of Providence's residents were hospitalized at Women & Infants Hospital and an additional 41.3% were hospitalized at Rhode Island, Miriam or Hasbro. Thus, despite the fact that Providence provided a larger number of admissions

to CharterCARE hospitals than any other community, that number still represented a small proportion of Providence resident admissions to any hospital.

Among the 2554 Providence resident hospitalizations at CharterCARE hospitals, 165 (6.4%) were uninsured, rather less than the 10% uninsured when all Providence hospitalizations are considered.

ED Visits by Providence Residents

During 2011, of the 41,220 ED visits by Providence residents, 5201 (12.6%) were at RWMC and 2925 (7%) were at SJHSRI. Comparable statistics for Rhode Island, Miriam and Hasbro were 27,161 (65.8%).

Among the 8,126 Providence resident ED visits to the CharterCARE hospitals, , (33.4%) were uninsured, compared to an uninsured rate of 30.8% for all ED visits in Providence.

Using these three communities as benchmarks, one can conclude that the CharterCARE hospitals share their major communities with two other health systems in Rhode Island, tend to have a slightly higher proportion of ED visits than hospitalizations from these communities and do not appear to disproportionately serve the uninsured in comparison with their competitors. In this sense, the picture they present is unremarkable.

On the other hand, RWMC and SJHSRI tend to admit a significantly higher proportion of their emergency room visits – 26.1% for RWMC and 24.0% for SJHSRI in 2012 against a statewide average of 19.2%. This pattern has held over the last three years with RWMC and SJHSRI being #1 and #2 respectively among non-specialty hospitals for proportion of admissions from the emergency room in two of the three years and #2 and #3 in the third year. Given the Prospect statistics on admissions to their California hospitals over the period 2006-2011, this pattern is not likely to change materially as a result of the joint venture. Coupled with average readmission rates when compared to the other Rhode Island non-specialty hospitals, this pattern suggests that "more effective courses of treatment may be available" for some part of the inpatient population served by these two hospitals.

Model for Transitions of Care and Investment in Primary Care

In accordance with the scientific public health literature, with best practices as promoted by the United States Department of Health and Human Services, and with long-standing experience in the State of Rhode Island, the Department promotes the development and maintenance of a robust primary health care system in the state.

Furthermore, in that the coordinated transitioning of patients from primary health care to hospital inpatient care, often via hospital emergency departments, on the one hand, and from hospital inpatient care back to primary health care, on the other, is recognized as critically important in the avoidance of prolonged illness episodes, preventable illness *sequelae*, unnecessary hospital admissions, and excessive burdens on family care-givers, the Department promotes well-planned and well-managed transitions of care between these two care settings.

In this context, the Department has devised two conditions for the joint venture of the CharterCARE hospitals with Prospect. The first asks Prospect to invest in the primary care system from which the CharterCARE hospitals draw patients and to which the CharterCARE hospitals discharge

patients, and the second asks Prospect to assure close collaboration between physicians employed by the CharterCARE hospitals and primary care physicians working in the community when admitting patients from the community to the CharterCARE hospitals, and when discharging patients from the CharterCARE hospitals to the community.

There is a wealth of literature describing the value of primary care to a balanced health care system, and a wealth of literature demonstrating the association of improved primary care supply with improved health outcomes, lower costs, and lower utilization of unnecessary services. "Primary care has been demonstrated to be associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalization and use of emergency department visits. Primary care can also help counteract the negative impact of poor economic conditions on health."¹⁰

The primary care to specialty ratio in Rhode Island, like the US as a whole, is about 30/70. Most health policy experts agree that the optimal ratio is 50/50. In this context, the existing health care system in Rhode Island is, by definition unbalanced. Half of all spending on or investment in physician services, therefore, should be on primary care for Rhode Island to achieve balance in its health care system.

Impact of Prospect on the Cost of Health Care in Rhode Island

As noted on its website, Prospect's model is to reduce costs and seek revenue sources that will enable it to improve its margins.

According to the Kaiser Family Foundation, Rhode Island spends \$8,786,000,000 in health care expenditures annually (2009 data) nearly 37% of which is on hospital services. The instant application presents the Department and the applicants with an opportunity to slow that trend.

Prospect's acquisition of the CharterCARE hospitals is likely to enable these two hospitals to exist for at least the next five years. Their survival beyond that time may well depend on the priorities Prospect and CCHP place on the investment of the "long term funding commitment". If Prospect invests in capital disproportionately, it may well miss the important opportunity for integration of the hospitals with the primary care physician community that is at least as, if not more, important than investment in bricks and mortar. This is underscored by the fact that virtually all the communities within the service area of the two hospitals utilize other hospitals and hospital systems to a greater extent than they utilize the CharterCARE hospitals. To the extent those other hospitals and systems invest in the primary care networks of those communities first, the CharterCARE hospitals may become marginalized despite any capital investments they make.

While impact on the economy continues to be an important factor to consider, it is of lesser importance in this instance than was the case in the recent reviews involving Landmark Medical Center and Westerly Hospital. In the case of RWMC and SJHSRI, contrary to the assertions of the hospitals, and notwithstanding the services they both provide and the efforts they have made over the last three years to achieve financial stability, either or both could close without significant job or income loss to the greater Providence community since most of the patients would be cared for by hospitals that are already major admitters of the affected population and most of the jobs would be relocated to these other hospital sites – all of which are within a ten mile radius of the existing hospitals. While the uncompensated care burden would also be shifted to the remaining hospitals, so long as the primary care infrastructure remained in the affected neighborhoods, the closures would likely have a positive

impact on system affordability. Nevertheless, the disruption to the communities would have short term effects that could be avoided by pursuing a middle path. While the long term survival of these two hospitals in the emerging environment remains in doubt, there is potential to move to a single license system that can enable the service consolidations and cost savings necessary to preserve the acute care hospital platform as well as reduce the need for capital investments to non-duplicative capital improvements. In this way, Prospect, which has experience operating multiple hospitals under a single license in both California and Texas, can emphasize investment in primary care sources of referral and physician-hospital integration efforts that may actually affect patient outcomes positively. This may then give Prospect an opportunity to not only preserve the Catholic philosophy of SJHSRI but to do so within a system focused on greater community integration than has heretofore been the case.

Given the various exceptions to preservation of all services at both hospitals set forth in the asset purchase agreement, it is not clear that the Department's concerns are materially different from those implied by Prospect in its articulation of reasons that may lead it to terminate, suspend, and/or modify services at the new hospitals within the five year period. Notwithstanding Prospect's articulation of those exceptions, it is a condition of the Department's approval that those exceptions not apply to inpatient substance abuse detoxification services, inpatient and day hospital psychiatric services and clinic services of SJHSRI.

Finding:

Given the forgoing discussion, it appears that this conversion can be in the public interest of the State of Rhode Island, subject to the conditions attached hereto.

#8: “For any conversion subject to this chapter, the Director....shall consider issues of market share especially as the affect quality access, and affordability of services.
{See section 22-17.14-28 (a) RIGL}

Discussion

The Department views this final criterion in light of the Federal Trade Commission’s merger review process as it relates to hospital conversion transactions.

The Department considered the following proxies for this criterion:

- Federal Trade commission ruling as it relates to market share.
- The degree to which preservation of or reductions in the market share of the existing hospitals would affect the quality, access and affordability of healthcare services within the state.

The transacting parties reported that no filing is required with the Federal Trade Commission for this transaction.

With regard to the issue of market share, in 2009, the Department’s consultant found that RWMC and SJHSRI had a combined market penetration exceeding 5% for all the cities and towns of Providence County, Kent County and Bristol County. In 2011, that remained true except for the town of East Greenwich.¹¹ In 2009, for the cities and towns of Washington County and Newport County, the combined market penetration of RWMC and SJHSRI was less than 5% with two exceptions (North Kingstown 5.3% and Tiverton 5.7%). By 2011, there was only one exception left, Richmond at 5% precisely. In 2009, the consultant noted that combined market penetration for the two hospitals was greater than 50% in Smithfield; greater than 40% in Johnston and North Providence; greater than 30% in Glocester; greater than 20% in Burrillville, Cranston and Providence; and greater than 10% in Bristol, East Providence, Foster, Lincoln, North Smithfield, Scituate and Warren. By 2011, the combined market penetration for the two hospitals did not exceed 50% in any community and Smithfield had become the only community with a penetration that exceeded 40%. Johnston and North Providence penetrations had slipped to the 30% range and Glocester was now in the 20% range. Burrillville, Cranston and Providence had all slipped below the 20% range to join Foster, Scituate and Warren at greater than 10%, with Bristol, East Providence, Lincoln and North Smithfield all falling below 10%.

In 2009, a comparison of market distribution of discharges for RWMC and SJHSRI showed that the percentage of inpatients that each hospital drew from corresponding cities and towns differed by 2% or less with the exceptions that SJHSRI got relatively more of its patients from North Providence and Johnston while RWMC got relatively more of its patients from Providence. Based on their combined market penetration, discharges from eight (8) cities and towns (Cranston, East Providence, Johnston, North Providence, North Smithfield, Providence, Smithfield and Warwick) accounted for 75% of their total discharges. In 2011, by the applicants’ own statistics, it now takes nine cities and towns to make up 75% of the hospitals’ total discharges, North Smithfield having been replaced by Pawtucket and Woonsocket.

Based on that analysis, the consultant concluded that the combination of RWMC and SJHSRI could increase the concentration of Rhode Island’s already concentrated marketplace, although not for tertiary services. Nevertheless, the Director, in the context of the times (Lifespan and CNE were applying

to combine) concluded that the creation of CharterCARE appeared to preserve the existing market share for the two licensed hospitals, would do little to change the then existing market share of these two hospitals or of the other hospitals in the state, and served as an appropriate, lower cost viable alternative to other dominant system hospitals.

Based on the 2011 data, the market share of the CharterCARE hospitals has actually decreased since the 2009 report . As a result, not only is the joint venture with Prospect going to have no immediate effect on market share but even were the services provided by these two hospitals to shift to the other dominant players in the Providence market, it is unlikely that such shift would have any significant effect on the relative concentration of those hospitals or on hospital prices.

Finding:

Based upon the discussion above, the approval of the instant conversion application is expected to have no effect on market share.

Final Decision of the Director of the Department of Health

The hospital conversion proposed by the transacting parties, Prospect Medical Holdings, Inc., Prospect East Holdings, Inc., Prospect East Hospital Advisory Services, LLC, Prospect CharterCARE LLC, Prospect CharterCARE RWMC, LLC, Prospect CharterCARE SJHSRI, LLC, and CharterCARE Health Partners, Roger Williams Medical Center and St. Joseph Health Services of Rhode Island is hereby approved by the Rhode Island Department of Health, subject to the terms and conditions outlined below:

1. The transacting parties shall implement the conversion, as detailed in the initial application, and as conditionally approved by the Director of Health.
2. The new hospitals shall adopt a transitions-of-care program to prevent unnecessary hospital admissions and re-admissions in accordance with the requirements set forth in Addendum 1, attached hereto.
3. The new hospitals shall participate in the Department's Prescription Monitoring Program (PMP), ensuring that within one month of the date of this Decision all medical doctors, nurse practitioners and physician assistants working in the emergency departments of the new hospitals shall be enrolled in the PMP; that for every prescription for Schedule II through IV, the prescriber shall document the findings and decision of that consultation in the patient chart; that all new practitioners to the new hospitals shall be enrolled in the PMP upon credentialing; and that all existing (non-emergency department) practitioners of the new hospitals shall be enrolled in the PMP upon re-credentialing.
4. The new hospitals shall offer opt-out adult (as defined by the U.S. Centers for Disease Prevention & Control) HIV testing on all emergency department patients at least once a year and report annually to the Department the rate of testing of the prior year.
5. The new hospitals shall offer annual seasonal influenza vaccines to 100% of the patients at discharge (September through April) and document each said offering in the patient's chart and report annually to the Department the rate of vaccination of the prior year.
6. As long as SJHSRI continues to provide pre-natal care at its clinic, the new hospitals shall, subject to the Ethical and Religious Directives, participate in all local (defined as the primary service area) and state-wide coalitions that work to improve prenatal care and to prevent teen pregnancies, including the Rhode Island Alliance and the Rhode Island statewide prematurity task force.
7. The new hospitals shall adopt evidence-based alcohol-abuse-screening during emergency department visits (SBIRT) for individuals aged fifteen (15) and over and provide annual reports to the Department of the number and types of referrals generated as a result of screening.
8. The new hospitals shall maintain compliance with The National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare.
9. The new hospitals shall analyze and report the mix of their emergency departments' and hospital discharge diagnoses in accordance with the provisions contained in Addendum 2.
10. The new hospitals shall expand their efforts to enroll patients in CurrentCare by offering enrollment to all patients seen in all ambulatory clinics and physician practices owned by the hospitals, to all patients seen at the emergency department, and to all patients at time of hospital admission or discharge. The new hospitals shall continue to comply with

all CurrentCare data submission requirements, including data that are currently being sent as well as any new requests by CurrentCare. The new hospitals shall make the CurrentCare viewer available to the emergency department, and all ambulatory clinics and physician practices owned by the hospital.

11. Prospect shall, not later than three (3) years after the effective date of the conversion, reduce the number of licensed hospital beds by forty-seven (47) licensed beds across the Prospect CharterCARE, LLC system. Prospect shall not be required to keep both hospitals open and operational for any minimum period. The remaining hospital beds shall include no fewer than 15 inpatient substance abuse detoxification beds and 95 inpatient psychiatric beds, such beds to be staffed post-conversion in accordance with industry standards, and to retain or build upon: a) the existing range of unique inpatient psychiatric services to ensure vital community issues are being addressed, including the hospitals' geriatric psychiatric units, alcohol and drug detoxification units, medical/psychiatric units, and intensive care units; and b) the existing continuum of outpatient psychiatric services (e.g. partial hospitalization) to ensure vital community interests are being addressed.
12. Prospect shall sustain the functions of the clinic services currently provided by SJHSRI.
13. Prospect shall implement a worker retraining program within 6 months after closing on the conversion and shall submit a copy of such program to the Department. There will be a retraining program required for staff reassignment. However, for laid off workers, the Human Resources Department at Prospect would design a program to assist laid off employees with placement opportunities in the healthcare field through job placement services and education on retraining opportunities in partnership with the Rhode Island Department of Labor and Training networkri.
14. The existing hospitals shall finalize the net settlement amounts due to the Rhode Island Medicaid program for the years 2006-2010 by June 15, 2014. An amount equivalent to the settlement amount paid by June 30, 2014 to RWMC by the State of Rhode Island will be paid within five business days of such payment to the State of Rhode Island by SJHSRI. Any remaining settlement balance owed thereafter by SJHSRI will be paid to the state in six equal monthly installments beginning on or about July 5, 2014 and ending on or about December 5, 2014.
15. The new hospitals shall participate in the Rhode Island Medicaid program, including fee for service and all managed care programs, in accordance with section 40-8-13.4 of the Rhode Island General Laws.
16. Prospect shall continue to implement the post-affiliation actions (2.2 through 2.11) imposed by the Director on the CharterCARE hospitals in 2009 that have not been implemented to date or are not otherwise subsumed in a condition of this approval.
17. The new hospitals shall conduct community health needs assessments, designed in collaboration with the Department, focused on the health needs of the residents of North Providence, Johnston, Smithfield, Foster, Glocester, and Scituate, for a mutually agreeable purpose of optimizing health outcomes in those communities.
18. The new hospitals shall work collaboratively with the Director on a program to reduce preventable hospitalizations and ambulatory sensitive emergency department utilization at the new hospitals equal to or below the statewide rate of preventable hospitalizations. The individual hospital baselines and the statewide rate will be determined by the Department subsequent to July 1, 2014 and the new hospitals will be afforded a three (3) year period within which to achieve specified goals to be

determined by the Department. Each new hospital shall participate in any collaborative programs to reduce preventable hospitalizations.

The following conditions are included pursuant to section 23-17.14-28 (b) of the Rhode Island General Laws, as amended:

19. Prospect shall maintain a governing body for Newco RWMC and for Newco Fatima (the licensees) the membership of which shall include a minimum of two (2) individuals who are uncompensated, independent and who reside in Rhode Island.
20. Prospect shall contribute annually, in conjunction with the initial and renewed licenses (in accordance with the provisions of RIGL 23-17-7), a sum of \$75,000 to support the state's coordinated health planning process.
21. Prospect shall adhere to reasonable restrictions on financial incentives to patients or health plan enrollees to receive hospital services outside of the state of Rhode Island.
22. Prospect shall make a minimum investment to support primary care in the Rhode Island communities served by the new hospitals in accordance with the provisions contained in Addendum 3; provided that neighborhood health stations may be permitted to occupy more than one location (i.e., a "neighborhood health station system") provided that such system include (1) an integration with behavioral health at each location of a neighborhood health station, (2) physical therapy and home health services within the neighborhood health station system that may be provided by a third party via formal contract with the neighborhood health station system and (3) that all of these services be available no less than sixty (60) hours per week with ten (10) being weekend hours.
23. Prospect shall not enter into any contract or other service or purchasing arrangements with an affiliated legal entity except for contracts or arrangements to provide services or products that are reasonably necessary to accomplish the health care purposes of the relevant hospital and for compensation that is consistent with fair market value for the services actually rendered, or the products actually provided.
24. Prospect CharterCARE, LLC shall report to the Director on annual distributions of profits to owners in a form and substance acceptable to the Director.
25. Prospect shall not provide any corporate allocation, or equivalent charge, to any affiliated organization(s) in any hospital fiscal year exceeding reasonable fair market value for the services rendered or the assets purchased or leased from such affiliate.

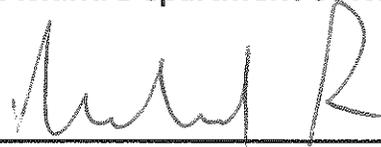
Additionally, pursuant to section 23-17.14-28 (d) of the Act, for the period of three (3) years following the effective date of the conversion,

26. Prospect shall file reports with the Department on or before March 1st of each calendar year detailing compliance with these conditions; and
27. Prospect shall pay for the costs of the Department of Health in performing such monitoring, evaluation and assessment of compliance with the conditions as the Director of Health may deem appropriate. Such costs are estimated to be no less than \$300,000, which amount shall be placed in escrow during the term of the monitoring period, provided, however, that any escrowed sum not expended by the Department of Health for such monitoring within the monitoring period shall be returned to Prospect within 60 days after the conclusion of the monitoring period.

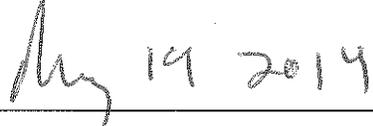
The conditions set forth above shall be enforceable and have the same force and effect as if imposed as a condition of licensure, in accordance with Chapter 23-17 and 23-17.14 of the Rhode Island General Laws, as amended. The Director of the Rhode Island Department of Health may take appropriate action to enforce compliance with these conditions.

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

Rhode Island Department of Health



**Michael Fine, MD
Director of Health**



Date

¹ The application is available online at www.health.ri.gov

² The Health Services Council exists under the authority of section 23-17-13 of the Rhode Island General Laws. It is a 24 member body that is advisory to the Director of Health for Change in Effective Control and Certificate of Need reviews.

³ Ivy Intermediate Holding Inc. ("IIH"), a Delaware corporation, owns 100% of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets, liabilities or operations. Ivy Holding, Inc. ("IH"), a Delaware corporation, owns 100% of the stock of IIH. IH is a holding company for such stock ownership. It has no other assets, liabilities or operations. The affiliated investment funds of Leonard Green & Partners, L.P. ("LGP") own approximately 61.3% of the common stock of IH. The affiliated funds are Green Equity Investors V, L.P., Green Equity Investors Side V, L.P. and Ivy LGP Co-Invest LLC. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

⁴ The data and conclusions in this section are all available at and derived from the U.S. Census Bureau website, www.census.gov as accessed on April 23, 2014.

⁵ This pledge is actually qualified. As set forth in the asset purchase agreement, Prospect may terminate, suspend or modify a service before the five years are up: 1) if it is no longer financially viable to provide the service, 2) if the new hospitals do not have sufficient physicians on staff to support the service, 3) if the service experiences a significant decrease in patient volumes for reasons beyond the control of the new hospitals, and 4) if the projected volume or clinical staffing for the service is insufficient to achieve or maintain a level of quality comparable to other general, acute care community hospitals in the service area of the new hospitals.

⁶ A transcript of the proceedings is available from the Department upon request.

⁷ See, e.g. the bibliography of studies in, "Review of the Literature on Hospital Mergers, 2009: Impact of Hospital Mergers on Access to Affordable Health Care, Access to Care for Underserved Populations, Balanced Health Care System, and Market Share," Harvey Zimmerman, June 2009.

⁸ See, "Charity Care: A Health Care Provider's Guide to Rhode Island Regulations," published by the Department and available online at www.health.ri.gov

⁹ These two laws, among others, are explained in relatively simple terms at www.cms.gov and at www.oig.hhs.gov

¹⁰ <http://www.hindawi.com/journals/scientifica/2012/432892>

¹¹ See, "Hospital Market Concentration and Market Share in Rhode Island," Harvey Zimmerman, June 26, 2009 and accessed at www.health.ri.gov under Hospital Conversions/Mergers Program; Publications.

Addendum 1

Model for Transitions of Care

With respect to the implementation of the provisions regarding EMERGENCY DEPARTMENT VISITS and subsections a. through d. inclusive thereof, and HOSPITAL ADMISSIONS and subsections a. through c. thereof, Prospect CharterCARE RWMC, LLC (“Newco RWMC”) and Prospect CharterCARE SJHSRI LLC, (“Newco Fatima”) shall at all times seek and obtain patient consultation, input, and patient consent. Such implementation shall also be executed consistent with applicable federal and state law and regulations.

1. EMERGENCY DEPARTMENT VISITS

a. **Patients who have primary healthcare providers:** When a patient seeks care from Newco RWMC’s or Newco Fatima’s emergency departments, the emergency department shall identify the patient’s primary healthcare provider, and shall make every reasonable effort to contact the patient’s primary healthcare provider for a consult before admitting the patient. If the patient is not hospitalized, before discharge, the emergency department shall make an appointment for the patient with the patient’s primary healthcare provider, to assure appropriate follow-up care. The emergency department shall also transmit the patient’s emergency department record, or a copy thereof if paper records are used, to the patient’s primary healthcare provider.

b. **Patients who do not have primary healthcare providers:** If the patient does not have a primary healthcare provider, and the patient is not hospitalized, before discharge from the emergency department, the emergency department shall make an appointment for the patient with a suitable healthcare provider within the hospital’s catchment area – taking into consideration the patient’s choice, the patient’s ability to access the primary healthcare provider geographically and financially – to assure proper follow-up care. The emergency department shall also transmit the patient’s emergency department record, or a copy thereof if paper records are used, to the patient’s new primary healthcare provider. To facilitate these activities, the emergency department shall maintain a list of primary healthcare practices located geographically within the hospitals’ catchment areas, and a list of which practices are accepting new patients. The emergency department will keep a count of the times in which an appointment with a suitable primary healthcare provider cannot be made for a patient who does not have a primary healthcare provider, and report this count in writing to the Rhode Island Department of Health (Department of Health) on a quarterly basis.

c. **Documentation:** The emergency departments shall document in the patient’s emergency department record the patient’s primary healthcare provider, all attempts to reach him or her, a summary of consults with the primary healthcare provider, and specifics of medical appointments made before discharge. Annually, Newco RWMC and Newco Fatima shall provide the Department of Health with counts of the number of times patients’ primary healthcare providers were reached before admitting patients to the hospital from the emergency department, and the number of times patients’ primary healthcare providers were not so reached.

d. **The EMS Innovations Project:** Newco RWMC and Newco Fatima will join the Department of Health’s EMS Innovations Project, to limit preventable emergency department use.

2. HOSPITAL ADMISSIONS

a. Patients who have primary healthcare providers: When a patient is admitted to an inpatient unit of Newco RWMC and Newco Fatima, before discharge, in order to facilitate an optimal transition-of-care from the inpatient setting to the discharge setting:

- The physician of record shall discuss a patient's transition-of-care needs regarding discharge from the hospital with the patient's primary healthcare provider in person or by telephone. If a primary healthcare provider is not immediately available to discuss a patient's transition-of-care needs, Newco RWMC's or Newco Fatima's physician of record (as the case may be) shall notify the patient's primary healthcare provider of an impending discharge at least 24 hours prior to discharge, and leave the physician of record's contact information.
- Newco RWMC and Newco Fatima shall provide nurse care managers and/or community health teams access to the patient for transition-of-care planning.
- Newco RWMC and Newco Fatima shall collaborate with nurse care managers and/or community health teams in the formulation of discharge plans.

Newco RWMC and Newco Fatima shall also, after consultation with and the consent of the patient, make an appointment for the patient with the patient's primary healthcare provider, to assure appropriate follow-up care. Newco RWMC and Newco Fatima shall also transmit a summary of the patient's inpatient record to the patient's primary healthcare provider.

b. Patients who do not have primary healthcare providers: When a patient is admitted to an inpatient unit of Newco RWMC or Newco Fatima, before discharge, in order to facilitate an optimal transition-of-care from the inpatient setting to the discharge setting:

- Newco RWMC or Newco Fatima (as the case may be) shall make an appointment for the patient with a suitable primary healthcare provider within the hospital's catchment area – taking into consideration the patient's choice and patient's ability to access the primary healthcare provider geographically and financially – to assure appropriate follow-up care. Newco RWMC or Newco Fatima shall also transmit a summary of the patient's inpatient record, or a copy thereof if paper records are used, to the patient's new primary healthcare provider. To facilitate these activities, Newco RWMC or Newco Fatima shall maintain a list of primary healthcare practices located geographically within the hospital's catchment area, and a list of which practices are accepting new patients. Newco RWMC or Newco Fatima will keep a count of the times in which an appointment with a suitable primary healthcare provider cannot be made for a patient who does not have a primary healthcare provider, and report this count in writing to the Department of Health on a quarterly basis.

c. Documentation: Newco RWMC and Newco Fatima (as the case may be) shall document in the patient's inpatient record the patient's primary healthcare provider, specifics of pre-discharge transition-of-care consultations and collaborative discharge planning, and specifics of medical appointments made before discharge. Annually, Newco RWMC and Newco Fatima shall provide the Department of Health with counts of the number of times patients' primary healthcare providers were reached for discussion before inpatient discharge, and the number of times patients' primary healthcare providers were not so reached.

Addendum 2

Quarterly, the Chief Nursing Officer of Newco RWMC and Newco Fatima shall review hospital discharges in the previous quarter, by primary discharge diagnosis, to ascertain the reasonableness of the mix of discharge diagnoses for an acute care hospital with the number of staffed beds at each, and report the results of that review in a brief report to the Department of Health. Quarterly reports shall be submitted to the Department of Health within 30 days of the end of a quarter, on May 1, August 1, November 1, and February 1 of each year, and shall contain:

- The count and proportion of hospital discharges from Newco RWMC and Newco Fatima in the previous quarter, by discharge diagnosis.
- A comparison with the proportion of hospital discharges in the relevant quarter from Newco RWMC and Newco Fatima, by discharge diagnosis, aggregated over the calendar years 2009-2013, the latter to be supplied by the Department of Health.
- A comparison with the proportion of hospital discharges in the relevant quarter from a set of community hospitals in Rhode Island,* by discharge diagnosis, for the preceding calendar year, the latter to be supplied by the Department of Health.
- A brief statement of the reasonableness of the mix of hospital discharge diagnoses from Newco RWMC and Newco Fatima in the previous quarter, and, if anomalies are identified, a brief plan of investigation to address the anomalies, both to be signed by the Chief Nursing Officers of Newco RWMC and Newco Fatima, as applicable.

*Kent Hospital, Memorial Hospital, and Landmark Medical Center

Addendum 3

Options for Investment for Supporting Primary Care in the Primary Service Area of Prospect CharterCARE, LLC ("Prospect CharterCARE")

\$2.25 million shall be used over a five year period to increase the supply of primary care physicians (defined as physicians practicing pediatrics, family medicine, and general internal medicine) in the primary service area of Prospect CharterCARE (defined as the municipalities of Johnston, North Providence, Smithfield, Cranston, Bristol and Warren, Rhode Island and neighborhoods in western Providence and northern Scituate, Rhode Island), as follows, or as may be modified by agreement with the Director of Health of the State of Rhode Island.

1/ Contribute \$250,000 over the course of five years to the medical student loan repayment program administered by the Rhode Island Department of Health, to pay medical student loan debt of primary care physicians practicing predominantly in the primary service area of Prospect CharterCARE.

AND

2/ Contribute \$2 million over the course of five years in one or more of the following ways:

- a) Establish a primary care residency training program at Newco RWMC to employ at least 6 residents per year over the course of 5 years.
- b) Develop Newco RWMC as a primary care residency training site affiliated with an established primary care residency training program, to employ at least 6 residents per year over the course of 5 years.
- c) Establish a neighborhood health station (defined as a multi-disciplinary group practice responsible for the primary health care of the population of a single, geographically-demarcated community within the service area of Prospect CharterCARE, employing 5 or more primary care physicians to serve 10,000 or more patients, at least 90% of whom reside within the geographically-demarcated community), either:
 - i) By developing a neighborhood health station from scratch, and employing 5 or more *new* primary care physicians to staff it, in addition to other *new* personnel.
 - ii) By consolidating several existing primary care practices located in the primary service area of Prospect CharterCARE, to form a unified neighborhood health station, and employing 5 or more *new* or *existing* primary care physicians to staff it, in addition to other *new* or *existing* staff.
 - iii) By collaborating with Bristol County Medical Center to create a neighborhood health station from existing assets.
 - iv) By recruitment of primary care physicians into the IPA and/or at-risk contracting model outlined in the Application.

- d) Establish a new community health center in the primary service area of Prospect CharterCARE in a collaborative venture with Tri-Town Community Action Agency, or WellOne Primary Medical and Dental Care, or Providence Community Health Centers, or East Bay Community Action Program.
- e) Establish the "Primary Care Practice Development Loan Fund" to provide low interest loans for establishing or expanding primary care practices in the primary service area of Prospect CharterCARE, as follows:
 - i. Work with the Director of Health to select a suitable third party for establishing and managing the Primary Care Practice Development Loan Fund, a low-interest, small business loan program for primary care practices, and to establish policies and procedures for making loans;

AND

- ii. Provide the Primary Care Practice Development Loan Fund with a fixed sum of money annually for each of five years, not to be less than \$200,000 nor more than \$400,000 per year, to assure the steady growth of loan assets to a total of \$1-2 million;

WHERE

- iii. "Primary care practice" is defined as a medical practice that chiefly provides family medicine, pediatrics, or general internal medicine, services to a stable panel of patients enrolled in the practice.
- f) Prospect CharterCARE, LLC may also invest by meeting the criteria relative to neighbor health stations and/or community health centers by incorporating such concepts into the existing SJSHRI clinics in Providence and Pawtucket; consistent with the Ethical and Religious Directions.

Appendices

Appendix A

Prospect Medical Holdings and CharterCARE Quality Review

Mary Reich Cooper, MD, JD

The material contained herein is the final report to Dr. Michael Fine, the Director of the Department of Health, Rhode Island, for purposes of assessing the quality and safety activities within the two organizations proposed for a merger/joint venture to create Prospect CharterCARE LLC: CharterCARE and Prospect Medical Holdings. This document is the written accompaniment to the presentation delivered to the Rhode Island Health Services Council on April 8, 2014, *the contents of which are appended in Attachment A*. **Based on my review of all available material, my role and experience as an expert consultant in the six domains of Quality, and my review of the statutory requirements for a Change in Effective Control and Hospital Conversion, my opinion is that the transacting parties satisfy all the requirements identified in RIGL 23-17-14.3 "Licensing of Health Care Facilities" and HCA 23-17.14-3, 23-17.14-4 and 23-17.14-8 that pertain to a quality review.**

My role and experience as a reviewer for the quality and safety activities relies upon 25 years of experience in quality and safety oversight, with experience in hospitals, health systems, and most recently, the Connecticut Hospital Association. I have no conflicts of interest in my role as quality and safety reviewer. I have written numerous articles and grants, served on state and national panels and committees, and taught multiple classes in various aspects of quality and safety. I led countless organizations through accreditation, regulatory and certification reviews, and I have performed quality reviews of hospitals at the request of hospital leadership. I have a degree in health law and passed the New York State Bar Exam, and I am trained in internal medicine and licensed in the states of New York, Georgia and South Carolina; I am not practicing law or medicine at this time. I was employed by Lifespan in Rhode Island as their Chief Quality Officer for five years, and I have served on the Board of Medicine and Licensure in Rhode Island for the past five years. *My curriculum vita is appended in Attachment B.*

There are a number of Rhode Island statutes and regulations from which I derived authority to conduct my review. The first was Rhode Island General Law 23-17-14.3, the Licensing of Health Care Facilities, which includes the requirements 1) [to assess] the character, commitment, competence, and standing in the community of the proposed owners, operators, or directors of the health care facility; 2) in cases of ... proposed change in owner, operator, or lessee, [to assess] the extent to which the facility will provide or will continue to provide, without material effect on its viability at the time of initial licensure or of change of owner, operator, or lessee, safe and adequate treatment for individuals receiving the health care facility's services; 3) [to assess] the extent to which the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services; and 4) [to assess] the extent to which the facility will provide or will continue to provide appropriate access with respect to traditionally underserved populations and in consideration of the proposed continuation or termination of health care services by the health care facility.

As part of the Hospital Conversion Act, 23-17.14-3 and 23-17.14-4, the statute requires the [assurance of] the viability of a safe, accessible, and affordable healthcare system that is available to all of the citizens of the state and a process to review whether for-profit hospitals will maintain, enhance or disrupt the delivery of healthcare in the state and to monitor hospital performance to assure that standards for community benefit continue to be met.

Within Hospital Conversion Act 23-17.14-8, there is a requirement stated to assess whether the character, commitment, competence, and standing in the community or any other proposed communities served by the proposed transacting parties is satisfactory and whether sufficient safeguards are included to assure the affected community continued access to affordable care. Additionally, there is a requirement that the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community and that the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

I did the quality review using the framework described by the Institute of Medicine in Crossing the Quality Chasm in 2001. The first domain of quality is Safety, fundamental and a threshold domain, and it means ensuring that the hospitals are not causing harm that should be preventable. I measured Safety by looking at regulatory reports, confidential data included in the HCA filings, and the national data, and compared the frequency to the community standard. There is no hospital in the country that has solved the problem of preventable harm, despite everyone's good intentions. I had to use my judgment and compare incidences and frequencies and assess whether any of the hospitals are outliers in frequency. Events that are reported to the state or to the accreditation agency are a subset of all preventable harm, especially when one looks at overutilization and underutilization, in addition to omissions and commissions. Safety must be paramount for any hospital to be a high quality organization.

Effective care, the next domain, is focused on the outcomes of care, or "are we doing something for the patient that positively impacts the clinical baseline with which the patient entered the hospital" Often, it is represented by evidence-based medicine and clinical guidelines, and the data in HospitalCompare and data reported to Quality committees and certification organizations may measure outcomes or process measures that are proxies for outcome measures. However, effective care may also be measured by looking at the availability and use of palliative care or the appropriate use of technology resources to treat certain diagnoses.

Patient-centered care, often measured by Patient Satisfaction (e.g., Press-Ganey or HCAHPS) also includes culturally and linguistically competent care, the presence of Patient and Family

Advisory Committees, and assessments that indicate that the patients' needs and desires are considered and held to be the center of the local decision making in the hospital. Hospitals across the country are beginning to adapt to a patient-centered model, but the Northeast has generally lagged.

Equitable care, or access, is the easiest to understand—not discriminating in allowing people appropriate care and making sure that the patient outcomes do not vary by race or language or age or ethnicity or gender or sexual status or payer status. Hospitals across the country have that anti-discrimination language included in their mission, but only recently have hospitals actually been measuring the outcomes. Multiple research studies show inequities in outcomes, and many of the biases are not even recognized by the person or persons perpetrating the inequities. Unfortunately, most hospitals are just starting to measure these outcomes, but currently one can ascertain the culture through a few proxies: Civil Rights violations; lawsuits by persons with impairments such as the deaf and hard of hearing; EMTALA violations; and Medicaid or Medicare fraud or sanctions are all examples of mechanisms to ascertain inequitable care.

Efficiency is the speed with which care is delivered in an organized fashion as opposed to timeliness, which is the speed that patients experience when they need a service. They are two sides of the same coin. Efficiency is usually measured for hospital inpatients through LOS, the length of stay, a measure which is a proxy for how rapidly inpatients are able to get things done in the health system. On a daily basis, hospitals download their census data and LOS is calculated by subtracting the discharge date from the admission date, and counting the days in between. There are national standards for length of stay, calculated from large groups of patients, and then averages are determined to provide comparisons. In some cases, patients may be risk adjusted to account for any confounding diagnoses, co-morbidities, or socio-economic determinants that may delay care. LOS is also called throughput, and most recently, it is being measured in Emergency Departments as part of Meaningful Use statistics.

Timeliness has very few national standards although in the outpatient arena there are a few measures that look at the time it takes to schedule an appointment or the time it takes to be seen in the Emergency Departments. However, hospitals with mature quality systems may look at timeliness. They do secret shopping or use surrogate patients to test the system and measure timeliness.

Six domains: Safe care, effective care, patient-centered care, equitable care, efficient care, and timely care all contribute to a quality program and it is not enough to demonstrate or measure one or two of the domains. A hospital or health system should be addressing all. As I reviewed all of the information, I was evaluating multiple pieces of information and ascertaining how each piece of information applied in each domain. **Although there are opportunities for all of**

the hospitals to measure themselves more comprehensively in every domain, each hospital falls within the community standard of what is measured and how that hospital performs compared to others.

The assessment included a review of the CEC application; a review of the HCA filing; retrieving data submitted by each hospital to the American Hospital Association's annual survey and looking for trends in the data; review of multiple pages of Medicare's HospitalCompare, HomeHealthCompare, and NursingHomeCompare websites as well as a review of the website WhyNotTheBest®, maintained by the Commonwealth Fund, which aggregates quality measures; review of accreditation and certification designations from the Joint Commission and DNV, and review of primary data if there was any question about the data on the website; review of the Kaiser Family Foundation data and the California Health Foundation data; review of available regulatory assessments from the Department of Public Health in California, the Department of Health in Rhode Island, and the Texas Department of Health and Human Services; in-depth internet and news research about all entities and all named principals, looking for evidence of fraud and abuse, lack of corporate compliance, Office of the Inspector General or Department of Justice and especially Office of Civil Rights violations, EMTALA violations, IRS violations, claims and lawsuits, and any other citations or violations or items of interest within publicly available information; and comparative or trending data where the data were available.

Subsequent to the review of documents and materials, a number of people from both CharterCARE and Prospect Holdings were interviewed, in person or via videoconferencing. All interviews were held in the conference room of the Attorney General or the law offices of the firm representing CharterCARE, if the interview required videoconferencing. Videoconferenced interviewees included the President and the CMO of Prospect Medical System based in California; the Vice President of Quality, Risk and Accreditation of Prospect Hospitals, based in California; and the Senior Vice President of Quality and Compliance for Nix Health Care System, based in San Antonio, Texas. Interviewees in Rhode Island included the Chief Nursing Officers of both St. Joseph's Hospital and Roger Williams Medical Center; the Senior Vice President and Chief Legal Counsel for CharterCARE; the CFO of CharterCARE; the Director of Finance for CharterCARE; and the CEO for CharterCARE.

The facilities that comprise CharterCARE include Roger Williams Medical Center, CharterCARE Home Health Services, Elmhurst Extended Care Facility, and St. Joseph's Health Services, which includes Our Lady of Fatima Hospital, St. Joseph's School of Nursing, St. Joseph's Health and Human Services, and Southern New England Rehabilitation Center. CharterCARE was only recently formed, in 2009, when the two hospitals and their associated entities joined to improve care, increase access for the communities served, improve efficiencies and decrease

costs of health care, but the hospitals each have been in business serving their communities, and competing with one another until the merger, since the late 1800s. Despite their successes as a result of the first merger, the impending changes in health care made their Board decide to pursue external partnerships that could be complementary to the hospitals and services of CharterCARE.

After a process where multiple prospective partners were considered as part of an RFP, CharterCARE sought a partnership with Prospect Medical Holdings to maintain local control and thereby continue their community mission; to retain their investment, both financial and emotional, in education and research; to improve their quality and their available resources with capital that was more easily available; and to make the transition from hospitals to accountable care organizations with a partner who had already done that successfully.

Prospect Medical Holdings is wholly owned by Ivy Intermediate Holdings, a Delaware corporation, and in turn owns and controls a multiple companies including those that control acute care and behavioral hospitals in California [SoCal Hospitals (Hollywood, Culver City, and Van Nuys) and Community Hospitals (LA and Norwalk)] and Texas (Nix Health Systems and Nix Community Hospital). All are community hospitals, non-academic, and have limited beds and services. They rely on hubs in the southern California or Texas regions, none of which they own, to take care of sicker patients who require more complex care. As such, they do not have the financial requirements of maintaining those more complex tertiary and quaternary hospitals.

Prospect Medical Holdings also owns and operates a network of primary care and specialty clinics in southern California and a nascent group of primary care and specialty clinics in Texas. Prospect Medical Holdings' owners were early adopters of risk contracting and currently manage approximately 150,000 lives under their own risk contracts and an additional 30,000 lives of other HMOs in southern California. They have extensive experience and both state and national recognition in risk contracting and managed lives. They are contracted with more than 1000 primary care providers, more than 2000 specialty providers and a number of regional tertiary and quaternary care hospitals in the southern California region.

Prospect Medical Holdings recognized that by concentrating in southern California their risk profile was wholly contingent on the laws and economic climate of that region, and that if health care changed, their stable financial picture could be altered. In addition, they faced ongoing competition from a number of hospitals including those affiliated with Kaiser Permanente. Their growth accelerated in 2010, with purchases of additional hospitals in southern California. The Texas hospitals were acquired in 2012. They are in discussion with hospitals in New Jersey as well as CharterCARE in Rhode Island. They aim to have a national footprint.

In an economic climate in Rhode Island that has been slow to revive after the Great Recession, and a health care climate that has been slow to change and accommodate the changes portended by the Affordable Care Act, Prospect Medical Holdings brings a glimpse of the future of health care in other parts of the country: greater risk contracting, fewer hospitalizations, longitudinal control over patients, and a focus on quality measures and outcomes. CharterCARE brings its own highlights to the table: academic medicine with its inherent learning culture, faith-based commitment to serve a community, a focus on research to increase the breadth of care possibilities, and partnerships with post-acute care operations such as highly regarded home health services and long-term care facilities. During the interviews, **I asked specifically and I was assured that all those items (academics and education, research, faith-based commitment to the community and partnerships with post-acute facilities) will remain were the merger/joint venture to go through.**

The hospitals have additional descriptions in the attached slide deck, from pages nine through 17, through data obtained from the American Hospital Association surveys in 2013. I was also able to access old surveys, and it is notable that all of the hospitals had trends of decreased admissions to their facilities over the past few years. Those trends are also reflected in the national data. Were the trends to continue, one can surmise that the tight controls that are now being placed on admissions and readmissions is having an impact on inpatient census. Given how expensive inpatient care in a hospital is, the trend is a desirable one if the care is available outside a hospital's four walls. However, early data show that trend may be reversing in many parts of the country as a result of the Affordable Care Act.

All of the hospitals under consideration participate with Medicare and maintain compliance with CMS' Conditions of Participation (CoPs). Although there have been occasional citations, all have been mitigated and/or rectified and show no pattern with which there is concern. All hospitals satisfy state regulatory requirements, as well, and all participate in the state Medicaid programs. Accreditation varies by hospital, but most of Prospect Medical Holdings' hospitals seem to be moving toward Det Norske Veritas, or DNV. **There are no issues with accreditation at any hospital, and all are currently accredited.** I have summarized the accreditation decisions in slides 19 through 27.

There are two interesting points contained within the accreditation information. The first is the model of accreditation that DNV advocates. That model is really a continuous improvement philosophy based on a hospital's compliance with its own policies and the CoPs from CMS; there are no additional standards. However, they expect hospitals to approach continuous improvement in a rigorous ISO model (International Organization for Standardization) and look for defects that reflect lack of compliance with their own policies.

The second point is that Prospect seems to have a different philosophy about external certifications currently. The good news about external certification is that it allows the hospitals to compare themselves to a national standard and the current external certifications are quite rigorous. But external certifications cost significant amounts of money and lots of time—not only to meet the standards but also to collect the data, report the data, host the certification surveys, and modify whatever the certification survey uncovers. There have been no data or generally accepted research that indicates that participating in an external certification process improves outcomes, and in fact, there are not even data showing that those hospitals with external certifications perform better than those hospitals without external certifications.

CharterCARE hospitals have multiple external certifications: stroke, diabetes, joints and other programs that are certified or in process. Prospect Medical Holdings has not pursued any external certifications through accreditation agencies. It is a statement of fact. It is not a judgment. I did inquire whether the CharterCARE certifications would remain and even be increased. **I was assured by both Prospect Medical Holdings and CharterCARE personnel that not only will the certifications be maintained but also that Prospect Medical Holdings can learn from CharterCARE and assess whether their other hospitals should be pursuing certifications, too.**

Quality metrics for the hospitals were chosen from a plethora of publicly reported quality measures. There are many concerns with public reporting of measures by various entities, the most serious one being that they reflect just a slice of care that is given in hospitals. That concern has lessened as more and more measures are added. Recently, the AAMC (American Association of Medical Colleges) published recommendations for publicly reported measures, and the recommendations are endorsed by a number of organizations. *The AAMC publication is appended in Attachment C.*

Currently, data for Medicare patients are reported quarterly for all hospitals that meet the sample sizes that CMS requires. In some cases, hospitals are too small to report any measures; critical access hospitals, with just a few beds, would fall into this category. Nix Community Hospital, outside of San Antonio Texas, has 18 beds and may qualify as a critical access hospital but I did not see it referred to as one. It may not be far enough away from other hospitals such that it meets the qualifications, but it is too small to meet the sample sizes for most of the measures.

Within a hospital, there may be measures that are not reported because there are not enough patients in that particular diagnosis group. For example, treating heart attack patients with primary angioplasty requires a catheterization lab and highly trained interventional cardiologists, 24 hours a day, 7 days a week, 365 days a year. The numbers of patients who present to the hospital with symptoms of an acute heart attack have to be large enough to

justify that level of resource and requires techs and nurses and data analysts in addition to the equipment and the cardiologists. For the hospitals being assessed, there are a number of measures for which there are not enough patients for the associated diagnoses, scattered throughout the data. As a result of there being data gaps within the hospitals' data, I chose a different model of assessing quality with publicly reported data.

The Commonwealth Fund started aggregating publicly reported measures approximately seven years ago, and the algorithms were developed by CMS or IPRO (the New York City regional QIO). They are available on WhyNotTheBest®. WhyNotTheBest® has been validated as accurately reporting rolled-up measures. As such, one can look at overall quality and at measures of rolled-up quality in heart attack care, pneumonia care, congestive heart failure care, and surgical care independently. I did not include each measure within those categories from the HospitalCompare website. I was looking for trends and culture and hospital-level performance rather than identification of processes that are not working within those hospitals, a level of review more applicable to the decision of whether "the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services". I also looked at overall mortality and at mortality in heart attacks, pneumonia and congestive heart failure, and state level readmissions data and compared those data to hospital level readmissions in Medicare patients.

One can look at state level data and national benchmarks of not only the top 1% (essentially 100% compliance), but also averages and top 10% measures. In a state such as Rhode Island, where any one hospital influences the data significantly (especially in some of the diagnoses), having these roll-ups calculated takes into account small samples, lack of participation (such as time to PCI, when there is no catheterization lab), and wide variations in outcomes due to small numbers. Rather than relying on unvalidated statistics, using WhyNotTheBest® gives me assurance that I can trust the data as the data are summarized.

The quality metrics are reported out on slides 28 through 69. I looked at four categories of data, which address various domains of quality, and the citation for the date I accessed the data is on page 29. Overall quality of care measures safety, effectiveness, and efficiency, and is represented on slides 30 through 39. Mortality represents the ultimate outcome measure, and those data are represented on slides 40 through 49. Slides 50 through 59 show the Patient Experience data which is Patient Centered Care. Readmissions data, a measure of effectiveness and safety, are included on slides 60 through 69.

For all of the quality measures, I used the same model from category to category. I first showed a map of the variation around the country for that measure, to illustrate how far we are from perfection. There is still a tremendous amount of variation and layering maps shows that the variation is not just hospital to hospital but occurs within hospitals, too. A hospital may perform

well on quality measures and perform badly on patient experience measures, for example. Next, I showed state level data, compared to national averages and the top 10% in each category. I then looked at all seven of the hospitals in that category and compared them to each other and had the state and national comparisons. Last, I looked at trends within each hospital.

For overall quality, there are places around the country that are performing at 100%, but what is striking is in how much of the country the data are unable to be aggregated because of small numbers in either a diagnosis or overall hospital patients. The top 10% is 99.55% compliance for overall quality, and both heart attack care and heart failure care are at 100% compliance with the measures for that top 10%. Pneumonia is at 99.58% and surgical care is 99.63% in the top 10% of hospitals. The national average for each of those is not far behind: 98.05% for overall quality, 98.31% for heart attack care, 96.40% for heart failure care, 96.17% for pneumonia, and 97.93% for surgical care. Rhode Island performs better in surgical care but worse than Texas and California in heart attack care, congestive heart failure, and pneumonia. At the hospital level, the Rhode Island hospitals perform better overall, but for some diagnoses Rhode Island is behind. There are no hospitals that are performing badly and the trend lines show that all have been improving. Several hospitals had data sets that were too small for valid comparisons. **The overall quality of all of the hospitals does not give me cause for concern.**

In mortality, the top 10% of hospitals overall score at 10.61% mortality but there is tremendous variation. Overall heart attack mortality is 13.30% while pneumonia and congestive heart failure are both at 9.90%; the national average for overall mortality is 12.31%, heart attack is 15.20%, congestive heart failure is 11.70%, and pneumonia average is 11.90%. California, Texas and Rhode Island are very similar in outcomes, both for overall mortality and the three diagnoses. There is even more variation among the hospitals for overall mortality and the three diagnoses, with almost everyone performing better than the national average but not within the top 10%. St. Joseph's is the only hospital consistently performing worse than the average, but just by fractions of per cents. Trend lines show some decreases but those may be random. **Mortality performance generally is better than average.**

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is the federal validated tool that is in the public domain and used to measure patient satisfaction comparatively. On a scale of one to ten, a random sample of discharges from each quarter is asked 27 questions about their stay. Ten HCAHPS measures (six summary measures, two individual items and two global items) are publicly reported on the Hospital Compare Web site (www.hospitalcompare.hhs.gov) for each participating hospital. Each of the six summary measures, or composites, is constructed from two or three survey questions. Combining related

questions into composites allows consumers to quickly review patient experience of care data and increases the statistical reliability of these measures.

The six composites summarize 1) how well nurses communicate with patients, 2) how well doctors communicate with patients, 3) how responsive hospital staff are to patients' needs, 4) how well hospital staff help patients manage pain, 5) how well the staff communicates with patients about medicines, and 6) whether key information is provided at discharge. The two individual items address the cleanliness and quietness of patients' rooms, while the two global items report patients' overall rating of the hospital, and whether they would recommend the hospital to family and friends.

Patient experience shows the middle of the country to be highly satisfied but the other parts of the country are variable in their percentages of highly satisfied. None of the three states with hospitals under review, e.g., Rhode Island, Texas or California, are top performers. **Evaluating the individual scores of the hospitals under review, most of the hospital domains in patient experience are at or below average, compared to the national average. None of the hospitals are top performers.** There is variability among hospital domains, with the information given at discharge consistently appearing in the highest spot. Despite the connection to Value-Based Purchasing, the scores have not improved a lot over the past several years. All hospitals are working on Patient Experience, but there has been little headway.

The last publicly reported metric for this report is readmissions. Readmissions occur within thirty days after an index case is discharged. Readmissions can occur for a variety of reasons. First there can be a complication of care and the patient is sent to the next level of care, and returns. Second, there can be a lack of communication between the hospital and the post-acute care partner or provider, and something may be missed or may be given more than should have been given, and the patient returns to the acute care setting. Third, there can be an unexpected event or infection that goes unrecognized before discharge and the patient returns. Fourth, the patient can fall, or get hit by a bus, or have something totally unrelated to the initial admission, but if it happens within thirty days of discharge and the patient goes back into the hospital, it is a readmission. Last, there can be a lack of appropriate care settings or care decisions, and the patient comes back into the hospital.

Publicly reported readmissions data result when a patient is re-admitted subsequent to an admission for heart attack, congestive heart failure, or pneumonia. The data reflect a rolling average over three years, and they are updated annually. The Eastern seaboard performs worse generally than the rest of the country, according to the national map, and in fact, that plays out in the state averages. Rhode Island does worse generally than the national average whereas California and Texas are at the national average. None of the states' readmissions data are close to the top 10%. Most of the reviewed hospitals' readmissions data are worse than the

national average for most measures, but many of the measures have shown improvement over the past several years. **Readmissions data for the hospitals being reviewed show all the hospitals to be performing at the same level.**

There were a number of additional areas of quality which were reviewed and which will be covered in the subsequent paragraphs.

Review the service lines and clinical services delivered by the hospital to ascertain whether adequate resources will continue to be available for those services: Data and information from the hospital descriptions, CEC and HCA filings, disease certifications, commitments to investments, commitments to specified service lines, and interviews with staff suggest a commitment to continuing the service lines which are currently being offered. The interviews with the Nix Health System staff spoke highly of an investment in the infrastructure and service lines there after their acquisition by Prospect Medical Holdings. Interviews with the CEO of CharterCARE reinforced the written commitments to investment in ongoing community services, oncology service lines and bone marrow transplant, and research and education. **There are no concerns about availability of adequate resources.**

Review bed availability, staffing, occupancy and maintenance of adequate resources to provide care: Review of transition plans, trends in census, plans for revisions of the hospitals to single rooms and whether there will be adequate resources to support the current inpatient model were supplemented by review of current national trends in inpatient utilization. Overall, the frequency of inpatient hospitalizations is decreasing throughout the United States, and that trend has been seen in Rhode Island as well and further decreases are expected. The only exception that may change that decline is if the Affordable Care Act encourages people who heretofore have not been insured to pursue medical treatment for conditions that require hospitalization. During the review of the hospitals' demographics I also reviewed nursing staffing. In California there are mandated staffing levels and Prospect Medical Holdings has frequently hired per diem and travel nurses if the nurse staffing there fell below prescribed levels. Even with the planned changes of the hospitals to single rooms, so as to increase patient satisfaction and to reduce the risk of infections, the planned reduction of nursing is minimal and the nurses' union and Prospect Medical Holdings have already had discussions about appropriate staffing. **There are no concerns about adequacy of staffing or maintenance of occupancy.**

Review Information Technology, including Electronic Health Records' Platforms and Investments, Access to Health Information Exchanges, Meaningful Use Certification, and HIMSS Analytics: I reviewed the Electronic Health Record platforms, the prevalence of and investment in technology, the availability of Health Information Exchanges, the Meaningful Use levels, and the HIMSS (Health Information and Management Systems Society) analytics. The hospitals in

Rhode Island are very advanced electronically compared to the other Prospect Medical Holdings hospitals. Rhode Island itself has already implemented a health information exchange, not yet available in Los Angeles or San Antonio. Roger Williams Medical Center has achieved HIMSS level 6, representing achievement in Clinical Decision Support Services, Computerized Provider Order Entry, closed loop of medication ordering and delivery, clinical documentation templates and utilization of PACS (electronic availability of images throughout the system). Roger Williams and Fatima are Meaningful Use Level 1 certified. Prospect Medical Holdings also has an electronic health record but the level of investment in technology does not appear to be as advanced as the level of investment CharterCARE has made. There is no indication that Meaningful Use Level 2 compliance with patient centered activities such as measurement of throughput in the Emergency Departments of the hospitals or development of a patient portal has yet been complicated. **There are no concerns envisioned with support of investment in technology.**

Review Public Health indicators for the populations served. Many of the Prospect Medical Holding's hospitals are in underserved areas with cultural and linguistic diversity. They serve all patients and Medicaid is represented not only in admissions but also in their at risk outpatient population. In Rhode Island, there is similar diversity, especially with the role as a sanctuary that Rhode Island has played. Data from the Kaiser Family Foundation, the California Health Foundation, and the demographics from the CEC and HCA filings show high incidence of the same kinds of public health issues in all three communities: obesity, diabetes, smoking risks and cancer, heart disease, teenage pregnancies, asthma and COPD, and poverty and unemployment, with attendant at risk behaviors such as opioid use, alcohol overuse, and family violence. All of the hospitals and their ambulatory practices have been focused on these patient populations. The hospitals in Texas and California have at risk Medicaid populations and all of the hospitals have high utilization by government funded programs. **The hospitals have demonstrated a commitment to serving the public health need.**

Review additional external certifications. The Rhode Island hospitals have invested in a number of Joint Commission certifications as noted earlier in the accreditation discussion. However there are additional certifications and registries such as Baby Friendly for birthing (none of the hospitals except Texas have any births, and they are not Baby Friendly certified); CARF-Commission on the Accreditation for Rehabilitation Facilities-which has been obtained by the Southern New England Rehabilitation Center; Magnet and Pathways to Excellence certification by the American Nurses Credentialing Center—St. Joseph's has started the Pathways effort; data registries such as NSQIP from the American College of Surgeons—none of the hospitals, the American College of Cardiology—none of the hospitals; and stroke center certification from the Joint Commission—the two Rhode Island hospitals only.

During the interviews, the leaders from both CharterCARE and Prospect Medical Holdings asserted that they will continue to pursue certifications in Rhode Island and bring that same perspective to the California and Texas hospitals.

Review for any citations for fraud and abuse. There were no citations of fraud or abuse or any criminal penalties found. Of note, Brotman Medical Center (now SoCal Culver City), two owners ago, was the site of a whistleblower whose allegations instigated the investigation that required Tenet Healthcare to pay back the federal government millions of dollars for overbilling and fraud.

Review other external grading agencies and companies. All grades from US News, Leapfrog, Consumer Reports and Healthgrades were reviewed. **All of the hospitals fared similarly, with C the most common grade.** None were ranked by US News.

Review PSO participation and information about events. All of the hospitals have electronic reporting systems and I discussed the frequency of reporting events and what they do for follow-up. All belong to Patient Safety Organizations. California reports outcomes of selected events on-line and fines organizations; there were no patterns of events in any hospital reviewed. I reviewed malpractice incidence and the amount of monies necessary for the tail that would need to be purchased for any outstanding malpractice cases. We discussed actions against physicians and staff at all hospitals. **The reporting systems and follow-up of adverse events consist of strong policies and processes and an organized process for follow-up.**

Review wholly owned nursing homes and home health agencies. Outcomes from the websites NursingHomeCompare and HomeHealthCompare were reviewed and **there are no significant findings.** The California hospitals do not have any wholly owned partner entities nor do the hospitals in Texas. The slides 79 to 81 reflect those scores. Prospect Medical Holdings has extensive experience in ambulatory practices and certification by California's Department of Health Care Services for their HEDIS measures.

Review the status of ACGME or AOA oversight of training programs. There are only two hospitals with training programs, both under the oversight of the ACGME. At Roger Williams Medical Center, an academic medical center with an association with Boston University Medical School, there are training programs in Medicine and a Pulmonary Medicine Fellowship. At Nix, there is a Sports Medicine fellowship. The pass rate for the Medicine residents is 75%. During the interviews, leadership at both CharterCARE and Prospect Medical Holdings asserted that **they would continue to invest in graduate medical education.**

Review Quality Improvement Activities. Based on a review of the structures, the measures, the reports, Board involvement and the reporting relationships within the hospitals, and augmented by discussion about the structure, process and outcomes of Quality and

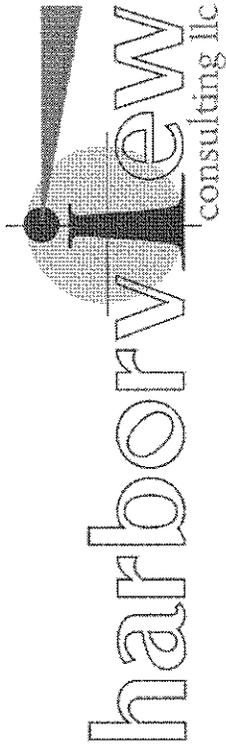
Performance Improvement with the Directors/VPs of Quality from each site, each hospital has a comprehensive quality improvement plan and appropriate reporting structures that ensure that the quality data and outcomes are presented to the Board and involve all clinical disciplines. **There are no concerns with the quality processes or structures.**

In summary, having reviewed both CharterCARE and Prospect Medical Holdings extensively from a quality perspective, I have no reservations about a joint venture between the two organizations.

Appendix B

CharterCARE/Prospect Acquisition Analysis

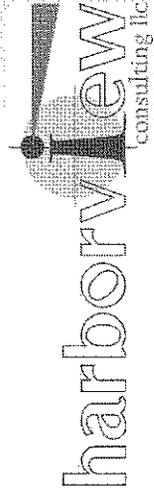
John J. Schibler, PhD, CPA



CharterCARE/Prospect Acquisition Analysis

John J. Schibler, Ph.D., CPA

May 6, 2014



Organization of Assessment

- ❖ Overview of the CharterCARE/Prospect Transaction
- ❖ Executive Summary of Findings
- ❖ Background on CharterCARE and Affiliates
- ❖ Background on Prospect Medical Holdings, Inc.
- ❖ Review of Prospect's Historic Financial Performance
- ❖ Other Considerations
- ❖ Forward Looking Risks

Notice: This report is based on the review of information provided and interviews conducted through April 30, 2014. There are still outstanding information requests. It is believed that this report is substantially complete. Should additional material information come about as the review is completed, an update to this report will be provided.

Overview of the CharterCARE/Prospect Transaction

- ❖ Financial structure of the transaction*:
 - ❖ \$45 million to be paid to CharterCARE Health Partners by Prospect at closing to be applied as follows:
 - \$16.5 to redeem St Joseph's Health Services 1999 Revenue Bonds
 - \$11.1 to redeem Roger Williams Medical Center 1998 Revenue Bonds
 - \$3.4 to redeem Roger Williams Realty Corporation 1999 Revenue Bonds
 - \$14.0 to be applied to the St Joseph Health Services of Rhode Island defined benefit pension plan
 - ❖ \$50 million of capital expenditures to be funded by Prospect over four years (in addition to normal routine capital expenditures estimated to be \$10 million)
- ❖ CharterCARE Health Care Partners will retain a 15% ownership in the new entity.

* Sources: Section 2.5 of Asset Purchase Agreement dated September 24, 2013 and the CharterCARE Health Partners Board of Trustees Resolution dated February 27, 2014.

Executive Summary of Findings

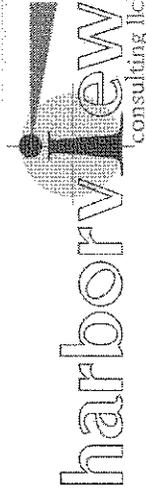
- ✧ Prospect Medical Holdings has adequate financial resources to fund the joint venture.
- ✧ Prospect will fund this acquisition through existing cash and an available line of credit.
- ✧ Analysis of Prospect's financial statements indicates that historical income from operations have been positive.
- ✧ EBITDA, Earnings Before Interest, Taxes, Depreciation and Amortization over the past four years (2010-2013) has ranged between 8.9% and 13.8% indicating the ability to service existing debt and make routine and strategic investments.
- ✧ As compared to similar publicly traded companies, various performance ratios suggest that Prospect compares favorably as to return on assets and overall balance sheet liquidity.
- ✧ Leverage ratios are generally higher than similar publicly traded companies suggesting higher risk; such higher leverage would be expected of growth companies.

Executive Summary of Finding (cont'd)

- ❖ As a result of my review, nothing has come to my attention that the transaction should not be approved.
- ❖ With respect to internal controls, while conducting the CharterCARE/Prospect acquisition analysis nothing has come to my attention that would indicate any significant weakness in internal controls.

Background: CharterCARE & Affiliates

- ✧ The CharterCARE affiliation was formed in 2011 with the combination of Roger Williams Medical Center and St. Joseph's Health Services and their related affiliates.
- ✧ Recognizing CCHP's weak capital position, the CharterCARE Board engaged a strategic consultant in March, 2011 to assist in developing and evaluating strategic partner alternatives.
- ✧ In evaluating partners, the key criteria used by CharterCARE were:
 - ✧ Consistent mission/vision
 - ✧ Access to capital for investment
 - ✧ Local control through joint venture
- ✧ In March, 2013 the CharterCARE Board approved a Letter of Intent with Prospect and, after due diligence, definitive agreements were signed in September, 2013



Background: CharterCARE & Affiliates (cont'd)

CharterCARE has incurred operating losses since inception, primarily driven by results at St. Joseph's. During this period of time, CharterCARE has implemented in excess of \$30 million of operational improvements.

	Unaudited 2011	Unaudited 2012	Unaudited 2013	Unaudited YTD Feb 2014
<i>(In millions)</i>				
Operating revenues	\$ 320.6	\$ 324.8	\$ 320.8	\$ 130.2
Operating expenses	331.6	328.1	328.3	138.9
Income (loss) from operations	\$ (11.0)	\$ (3.3)	\$ (7.5)	\$ (8.7)
EBIDA	\$ 5.1	\$ 10.6	\$ 5.8	\$ (3.5)
EBIDA Margin	1.6%	3.3%	1.8%	-2.7%

Source: 2011-2013 unaudited financial statements

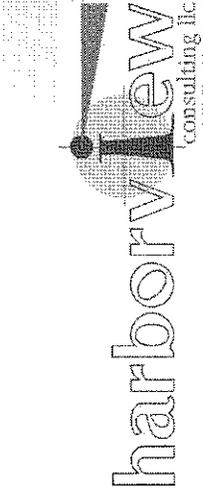
Background: CharterCARE – Roger Williams

Generally, Roger Williams Medical Center has had approximately break-even operations throughout the past three years.

	2011	2012	2013	YTD Feb 2014
Operating revenues	\$ 154.9	\$ 163.4	\$ 163.2	\$ 66.8
Operating expenses	153.7	162.0	164.2	68.5
Income (loss) from operations	\$ 1.2	\$ 1.4	\$ (1.0)	\$ (1.7)
EBIDA	\$ 7.5	\$ 7.1	\$ 4.2	\$ 0.4
EBIDA Margin	4.8%	4.3%	2.6%	0.6%

EBIDA = Earnings Before Interest, Depreciation and Amortization

Sources: 2010-2012 audited financial statements; 2013 and 2014 unaudited financial statements



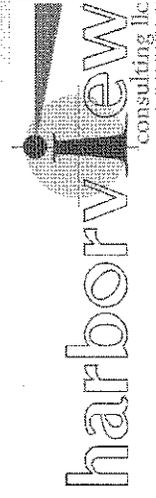
Background: CharterCARE – St. Joseph

St. Joseph Health Services has consistently incurred operating throughout the past three years although declining in the last two years. These operating deficits, along with a significant unfunded pension liability, has resulted in an overall deficit in unrestricted net assets of \$79 million.

<i>(In millions)</i>	Unaudited		Unaudited YTD Feb 2014	
	2011	2012		2013
Operating revenues	\$ 148.1	\$ 143.9	\$ 140.1	\$ 55.5
Operating expenses	159.8	148.2	143.9	61.0
Income (loss) from operations	\$ (11.7)	\$ (4.3)	\$ (3.8)	\$ (5.5)
EBIDA	\$ (4.5)	\$ 2.6	\$ 3.0	\$ (3.0)
EBIDA Margin	-3.0%	1.8%	2.1%	-5.4%

EBIDA = Earnings Before Interest, Depreciation and Amortization

Sources: 2010-2012 audited financial statements; 2013 and 2014 unaudited financial statements

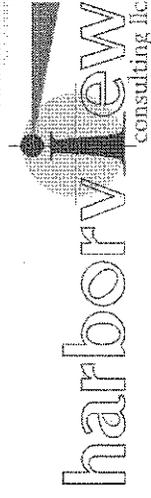


Background: CharterCARE & Affiliates

- ✧ Over the past three years, CharterCARE has implemented in excess of \$30 million of operating improvements which include:
 - ✧ Productivity improvements
 - ✧ Revenue cycle improvements
 - ✧ Consolidation of certain administrative services
- ✧ Given CharterCARE's operating performance, as well as funds available, CharterCARE does not have the capacity to make the necessary capital investment required to remain competitive.

Background: Prospect Medical Holdings, Inc.

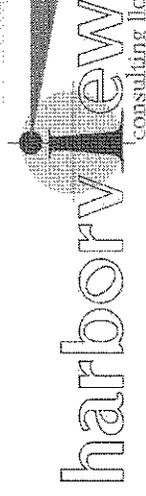
- ❖ Prospect Medical Holdings, Inc.'s (Prospect) financial statements include the operations of eight hospitals (as of September 30, 2013) in California and Texas. In addition Prospect has a Medical Group that manages care under capitation arrangements. As of September 30, 2013, Hospital Services and the Medical Group represented approximately 68% and 31% of total net revenues, respectively.
- ❖ Prospect Healthcare is a for-profit healthcare organization and is therefore subject to various federal and local taxes. Prospect is an S-corporation (tax designation) and as such the entities are disregarded entities for taxation purposes. Taxes are the responsibility of and paid by the parent, Ivy Holdings, Inc.
- ❖ Generally each acquired entity operates within a separate corporate structure (s) and are consolidated into Prospect Medical Holdings, Inc.



Review of Prospect's Historic Financial Performance

- ✧ I have reviewed Prospect's historic financial performance and highlights follow.
- ✧ In order to provide a comparison benchmark, in my opinion, it would not be appropriate to compare Prospect against published non-profit healthcare ratios due to different capital and operating structures. Therefore, I developed several benchmark ratios using the published results for the period 2010 through 2012 (most recent available) of the following publicly traded companies*:
 - ✧ Community Health Systems
 - ✧ Health Management Associates
 - ✧ Lifepoint Hospitals
 - ✧ Tenet Healthcare Corporation
 - ✧ Universal Healthcare Services, Inc.
 - ✧ HCA Holdings, Inc.

*Source: S&P Industry Surveys – Healthcare: Facilities, 2013



Review of Prospect's Historic Performance (cont'd)

Prospect Medical Holdings has had consistent operating income over the four years. In addition, EBITDA margins have ranged from 8.9% to 13.8%

<i>(In millions)</i>	2010	2011	2012	2013
Operating revenues	\$ 439.1	\$ 511.0	\$ 658.8	\$ 713.7
Operating expenses	394.8	479.4	580.7	633.7
Income from operations	\$ 44.3	\$ 31.6	\$ 78.1	\$ 80.0
EBITDA	\$ 57.0	\$ 45.3	\$ 69.7	\$ 98.8
EBITDA Margin	13.0%	8.9%	10.6%	13.8%

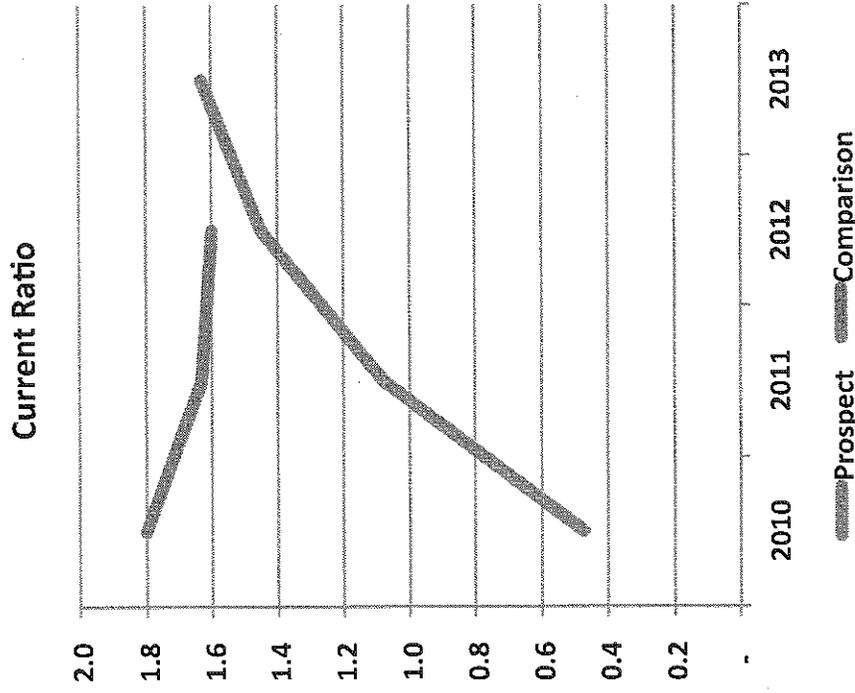
EBITDA = Earnings Before Interest, Taxes, Depreciation and Amortization

Source: Prospect audited financial statements for the respective periods.

Review of Prospect's Historic Performance:

Current Ratio

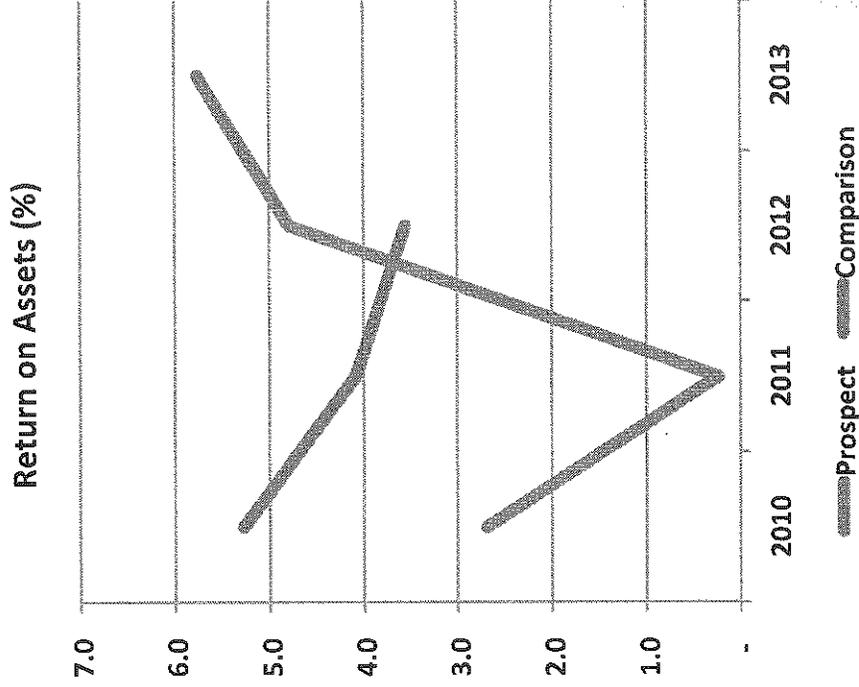
- ✧ The current ratio is the relationship between current assets and liabilities and measures a company's ability to pay short-term obligations.
- ✧ Prospect's current ratio has been below similar companies in 2010 and 2011; however, trending upward approaching that of peers in 2012 and 2013.



Source: Prospect Ratios have been derived from underlying audited financial statements.

Review of Prospect's Historic Performance: Return on Assets (ROA)

- ✧ Return on Assets (ROA) is the relationship between net income and total assets. ROA is an indicator of how profitable a company is relative to its total assets.
- ✧ Historically, Prospect has experienced a lower ROA when compared to similar companies. More recently, Prospect ROA is slightly better than similar companies.



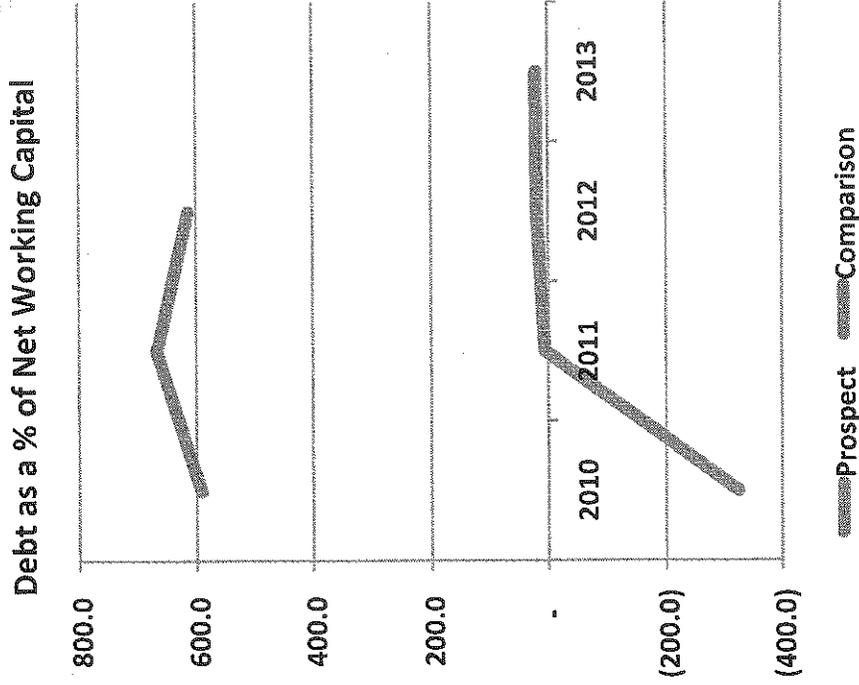
Source: Prospect Ratios have been derived from underlying audited financial statements.

Review of Prospect's Historic Performance: Debt as a Percent of Net Working Capital

- ❖ Debt as a percent of net working capital provides insight into the ability to pay long-term debt from current assets after paying current liabilities.
- ❖ Prospect's relationship between debt and working capital is lower when compared to similar companies to similar publically traded companies.

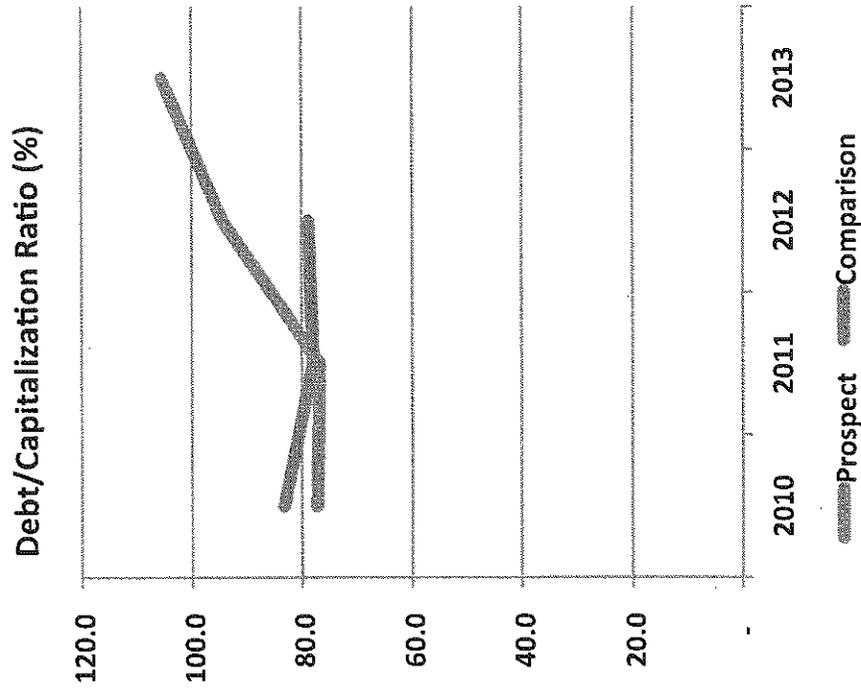
Note: In 2010, \$171 million of long-term debt was classified as current.

Source: Prospect Ratios have been derived from underlying audited financial statements.



Review of Prospect's Historic Performance: Debt/Capitalization (%)

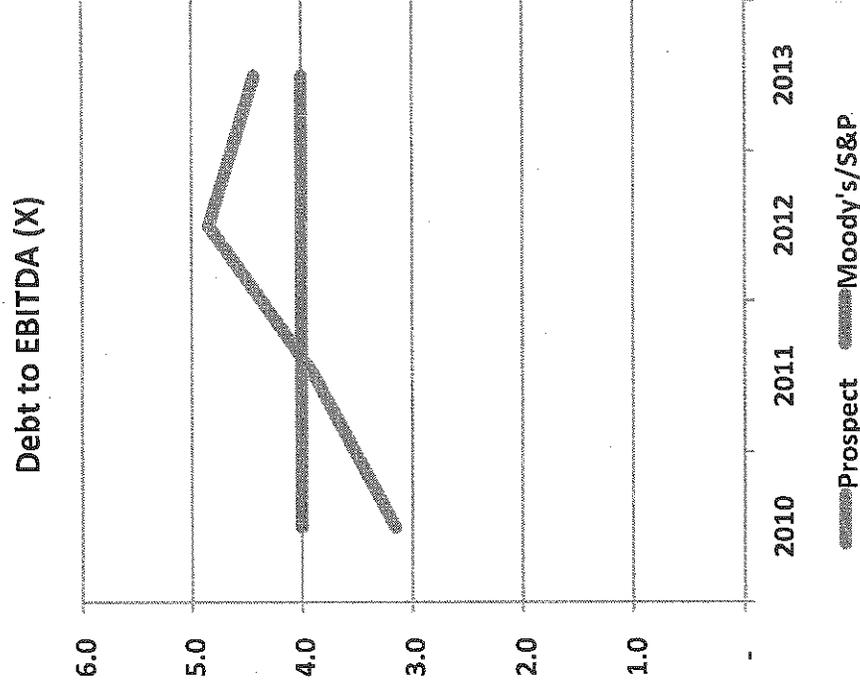
- ✧ The Debt/Capitalization (%) is the relationship between total debt, both short- and long-term, and capital. It is a measure of a company's financial leverage and indicates what proportion of debt is used to finance its assets.
- ✧ Prospect uses more debt to finance to finance assets as compared to similar publically traded companies.



Source: Prospect Ratios have been derived from underlying audited financial statements.

Review of Prospect's Historic Performance: Debt to EBITDA (X)

- ✧ The Debt to EBITDA ratio is a measure of leverage.
- ✧ Prospect's debt to leverage ratio is higher than Moody's "target" 4.0X
- ✧ Moody's has indicated that they would view Prospect's ability to sustain a leverage ratio of 4.0 positively.



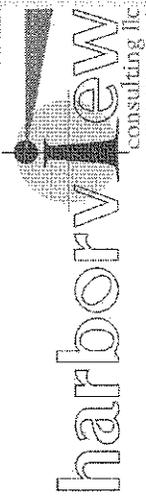
Source: Prospect Ratios have been derived from underlying audited financial statements.

Review of Prospect's Historic Performance: Summary

- ✧ As compared to similar publicly traded companies, more recently Prospect compares favorably as to return on assets and overall balance sheet liquidity.
- ✧ Prospect uses more debt to finance assets as compared to similar publicly traded companies. Leverage ratios are generally higher than similar publicly traded companies suggesting higher risk such higher leverage would be expected of growth companies.
- ✧ As of September 30, 2013 Prospect has a deficit in stockholders equity of \$32 million reflecting distributions to Prospect's parent, Ivy Holdings of \$88 and \$100 million in 2012 and 2013, respectively. Prospect has represented that there are no intentions to make additional distributions.

Review of Prospect's Historic Performance: Summary (cont'd)

- ✧ The CharterCARE acquisition will not require Prospect to seek additional financing. Prospect intends to finance the acquisition using cash generated from operations, including \$86 million of cash and cash equivalents as of September 30, 2013. In addition, Prospect has available a \$60 million revolving credit facility.
- ✧ Currently Prospect carries ratings on their long-term debt (\$419 million outstanding at September 30, 2013) from both Moody's (B2 – stable outlook) and Standard & Poor's (B – stable outlook):
 - ✧ Both ratings are considered speculative
 - ✧ Noted risks which include:
 - ✧ Considerable financial leverage
 - ✧ Small scale and concentration of operations in Southern California and California Medicaid Program
 - ✧ Expectation of continued acquisition activity



Other Considerations

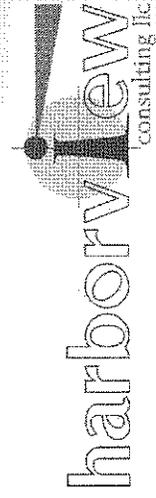
- ✧ Prospect intends to assume all payor contracts. In addition they have agreed in principle with Blue Cross with respect to two new plans—Medicare Advantage and a reduced premium product.
- ✧ With respect to internal controls, while conducting the CharterCARE/Prospect acquisition analysis nothing has come to my attention that would indicate any significant weakness in internal controls through examination of management letters issued by each organization's respective independent auditors.

Forward Looking Risks

- ❖ While Prospect has demonstrated good performance historically, changes in the healthcare market pose certain risks. These risks are not specific to Prospect; however, they may result in additional challenges in maintaining strong operating performance and could result in future operating performance varying from historical trends:
 - ❖ Health care reform poses a level of uncertainty as new regulations, delivery models, and reimbursement methodologies evolve.
 - ❖ Federal sequestration will result in payments from Medicare to providers being reduced
 - ❖ States are reevaluating Medicaid payments to providers as a result of fiscal pressures and expanding Medicaid coverage in the context of healthcare reform.
 - ❖ The protracted economic recession has resulted in significant increases in uninsured patients.
 - ❖ Increased competition from other providers within and outside of Rhode Island.
 - ❖ Ability to continue to attract skilled clinical professionals to meet increasing care demands.
 - ❖ Changes in federal and local tax policy.

CharterCARE/Prospect Acquisition Analysis

ADDITIONAL SUPPORTING INFORMATION



Scope of Work

- ✓ Performed an analysis of transacting parties' financial statements to assess the reasonableness of the proposed combination.
- ✓ Participated in interviews of key management personnel of CharterCARE and Prospect
- ✓ Provided expertise in hospital/healthcare accounting on as as needed basis
- ✓ Provided a final written report that is clear and concise, suitable for comprehension by those professionals not engaged in the auditing/ accounting profession.
- ✓ Performed other related activities that were requested by the Department.
- ✓ Remained alert for any conditions observed during the review that would give rise to concerns about internal controls.