

216-RICR-40-10-23

TITLE 216 – DEPARTMENT OF HEALTH

CHAPTER 40 – PROFESSIONAL LICENSING AND FACILITY REGULATION

SUBCHAPTER 10 - FACILITIES REGULATION

PART 23 – Hospital Conversions

23.1 Authority

This Part is promulgated pursuant to the authority conferred under R.I. Gen. Laws § [23-17.14-31](#) for the purpose of establishing minimal standards for the review of hospital conversions in this state, and to fulfill those purposes set forth in R.I. Gen. Laws § [23-17.14-3](#).

23.2 Incorporated Materials

These regulations hereby adopt and incorporate the Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, ("Title VI") by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations, in order to ensure that communications and language assistance is offered, individuals are informed about the availability of language assistance, competence of individuals providing language assistance is assured, and easy-to-understand materials and signage are provided.

23.3 Definitions

- A. Wherever used in these rules and regulations, the terms listed below shall be construed as follows:
1. "Acquiree" means the person or persons which lose(s) any ownership or control in the new hospital, as the terms "new hospital" and "person(s)" are defined within the Act.
 2. "Acquiror" means the person or persons which gain(s) an ownership or control in the new hospital, as the terms "new hospital" and "person(s)" are defined within the Act.
 3. "Act" means R.I. Gen. Laws Chapter 23-17.14, entitled "The Hospital Conversions Act."

4. "Affected community" means any city or town within the state of Rhode Island wherein an existing hospital is physically located and/or those cities and towns whose inhabitants are regularly served by the existing hospital.
5. "Affiliate" means a legal entity as defined in R.I. Gen. Laws § 23-17-2(1).
6. "Assets" means cash, cash-equivalents and other hard assets that can be converted into cash, including: cash on hand, savings accounts, checking accounts, Certificates of Deposit (CDs), money market accounts, stocks (common and preferred), bonds, mutual funds, IRAs, 401(k)s, 403(b)s, 457s, cash-in-value of life insurance policies, personal property, motor vehicles other than for personal use, second homes and rental properties. Excluded from assets are a primary residence and a motor vehicle for personal use.
7. "Assets protection threshold" means the maximum amount of assets that may be held and still allow the patient/guarantor to be eligible for full charity care. The assets protection threshold shall be \$8,000 for singles and \$12,000 for family units for 2006 and thereafter increased annually by the most current Consumer Price Index. Provided, however, that in instances in which an individual may be eligible for the state's Medical Assistance Program, a hospital may apply a lower threshold consistent with a threshold utilized by the state's Medical Assistance Program for the purpose of that individual qualifying for the state's Medical Assistance Program(s).
8. "Bad debt" means services provided and billed, but reported to be uncollectible, and demonstrated as such in the audited financial statements. Bad debt shall be cost-adjusted by applying a ratio of cost to charges from the hospital's Medicare Cost Reports to the "Provision for Bad Debts" (or equivalent) in the "Statements of Operations" (or equivalent) in the hospital's Audited Financial Statements.
9. "Charity care" means health care services provided by a hospital without charge to a patient and for which the hospital does not and has not expected payment. Said health care services shall be rendered to patients determined to be uninsured, underinsured or otherwise deemed to be eligible at the time of delivery of services. Charity care services are those health care services that are not recognized as either a receivable or as revenue in the hospital's financial statements. Charity care shall not include health care services provided to individuals for the purpose of professional courtesy without charge or for reduced charge. Under no circumstances shall bad debt be deemed to be charity care. Charity care

shall be cost-adjusted by applying a ratio of cost to charges from the hospital's Medicare Cost Reports to charity care charges-foregone.

10. "Community benefit" means the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with persons who are hospitalized or are receiving hospital services, and shall also include, but not be limited to, charity care and uncompensated care. Community benefit activities may also include the following:
 - a. Programs, procedures, and protocols that meet the needs of the medically indigent;
 - b. Linkages with community partners that focus on improving the health and well-being of community residents;
 - c. Contribution of non-revenue producing services made available to the community, such as fitness programs, health screenings, or transportation services;
 - d. Public advocacy on behalf of community health needs;
 - e. Scientific, medical research, or educational activities.
11. "Conversion" means any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets thereof, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of such transfer, a person, together with all persons affiliated with such person, holds or owns, in the aggregate, twenty percent (20%) or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital.
12. "Department" means the Department of Health.
13. "Director" means the Director of the Rhode Island Department of Health.

14. "Emergency care" means care provided in situations or circumstances involving the sudden onset of a medical, dental, mental or substance abuse condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.
15. "Equity" means non-debt funds contributed towards the capital costs related to a change in owner or change in operator of a hospital which funds are free and clear of any repayment obligation or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.
16. "Essential services" means hospital services that are reasonably required to diagnosis, 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.
17. "Existing hospital" means the hospital as it exists prior to the acquisition.
18. "Family unit" means a group of two or more persons related by birth, adoption, marriage, or other legal means who either live together or who live apart and are claimed as dependents.
19. "Federal poverty levels" or "FPL" mean the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2).
20. "For-profit corporation" means a legal entity formed for the purpose of transacting business which has as any one of its purposes pecuniary profit.
21. "Free care" and "no cost care" means charity care.
22. "Guarantor" means a person or persons who has accepted or is required to accept responsibility for the patient's hospital bills.
23. "Hospital" means a person or governmental entity licensed in accordance with R.I. Gen. Laws Chapter 23-17 to establish, maintain and operate a hospital, for-profit and not-for-profit.

24. "Income" means the actual or estimated total annual cash receipts before taxes from: salaries, wages, self-employment income, child care income, rental income, unemployment compensation, temporary disability insurance, child support, alimony, workers' compensation, veterans' benefits, social security payments, dividend and interest income, royalties, private and public pensions, and public assistance. Also included in income are: strike benefits, net lottery and gambling winnings and one-time insurance payments or injury compensation received in the calendar year in which the financial aid is sought for the hospital services.
25. "Incumbent" or "Recently incumbent" means those individuals holding the position at the time the application is submitted and any individual who held a similar position within one (1) year prior to the application's acceptance.
26. "New hospital" means the hospital as it exists after the completion of a conversion.
27. "Not-for-profit corporation" means a legal entity formed for some charitable or benevolent purpose and not-for-profit which has been exempted from taxation pursuant to Internal Revenue Code Section 501(C)(3) [26 U.S.C. § 501(c)(3)].
28. "Outpatient care areas" means outpatient clinical space and/or programs for which the hospital charges a facility fee or other hospital billing.
29. "Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies, and insurance companies), state or political subdivision or instrumentality of the state.
30. "Primary care services" means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. In most instances, primary care is focused on the point at which a patient first seeks assistance from the health care system for non-emergency services. Primary care services include, but are not limited to, such services as family practice, pediatrics, internal medicine, obstetrics/gynecology, and mental health services.
31. "Rhode Island resident" means an individual whose primary permanent residence is within the State of Rhode Island, regardless of citizenship or immigration status.
32. "State agency" means the Rhode Island Department of Health.

33. "Transacting parties" means any person or persons who seeks either to transfer or acquire ownership or a controlling interest or controlling authority in a hospital which would result in a change of ownership, control, or authority of twenty percent (20%) or greater.
34. "Uncompensated care" means a combination of free care, which the hospital provides at no cost to the patient, bad debt, which the hospital bills for but does not collect, and less than full Medicaid reimbursement amounts.
35. "Uninsured" means those individuals who do not have coverage under private or employer-sponsored health insurance or another government health plan, and who continue to lack such coverage.

23.4 General Requirements and Procedures

- A. Any hospital conversion, as defined in in this Part, requires review and approval from the Department of Health in accordance with the provisions of R.I. Gen. Laws § [23-17.14-5](#).
- B. All hospitals, including all new hospitals as defined in § 23.3 of this Part, shall be subject to the provisions of the rules and regulations for Licensing of Hospitals (Part 4 of this Subchapter) promulgated by the Rhode Island Department of Health.
- C. Any effect on hospital licensing fees is pursuant to R.I. Gen. Laws § [23-17.14-20](#).
- D. Concurrent approval of proposed conversions and proposed change in owner, operator or lessee is pursuant to R.I. Gen. Laws § [23-17.14-28](#).
 1. Reviews of applications for changes in the owner, operator, or lessee of licensed hospitals shall be conducted in accordance with the requirements set forth in the rules and regulations for Licensing of Hospitals (Part 4 of this Subchapter).

23.5 Conversion Application

- A. Information required in the initial application for conversions is pursuant to R.I. Gen. Laws § [23-17.14-6](#). Additionally, hospitals must provide:
 1. All information relevant to the criteria that the Department is required to consider pursuant to §§ 23.6 and 23.7 of this Part.

2. Any additional information pertaining to the conversion that the state agency may deem necessary for analysis of the applicable considerations outlined in §§ 23.6 and 23.7 of this Part.
 3. With respect to all information required pursuant to § 23.6 of this Part, the transacting parties shall upgrade and update said information through to the time of the Director's decision and the transacting parties shall have a continuing duty to supplement previously submitted information with supplemental, updated, and upgraded information.
- B. Two (2) copies of the initial application shall be provided to the Department of Health by United States mail, certified, return receipt requested, pursuant to R.I. Gen. Laws § [23-17.14-6\(b\)](#);
- C. Except for information determined in accordance with R.I. Gen. Laws § [23-17.14-32](#) to be confidential and/or proprietary, or otherwise required by law to be maintained as confidential, the initial application and supporting documentation shall be considered a public record and shall be available for inspection upon request.

23.6 Review of For-profit Conversions

- A. Review process is pursuant to R.I. Gen. Laws § [23-17.14-7](#).
- B. In reviewing an application for a conversion involving hospitals in which one (1) or more of the transacting parties is a for-profit corporation as the acquiror, the Department shall consider the criteria stated in R.I. Gen. Laws § [23-17.14-8](#) and:
1. Issues of market share especially as they affect quality, access, and affordability of services.

23.7 Review of Not-for-Profit Conversions

- A. All conversions which are limited to not-for-profit corporations which involve the establishment, maintenance, or operation of a hospital shall require prior approval of the Department. The review shall proceed pursuant to R.I. Gen. Laws § 23-17.14-9. The transacting parties shall file an initial application pursuant to the provisions set forth in R.I. Gen. Laws § 23-17.14-6 and § 23.5 of this Part.
- B. The Department shall adhere to the process set forth in R.I. Gen. Laws § [23-17.14-10](#) in reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations.

C. In reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations, the Department shall consider the criteria stated in R.I. Gen. Laws § [23-17.14-11](#) and:

1. Issues of market share especially as they affect quality, access, and affordability of services.

23.8 Review of Other Conversions

Review of conversions involving a for-profit hospital as the acquiree is conducted pursuant to R.I. Gen. Laws § [23-17.14-12](#).

23.9 Expedited Review

Expedited review is conducted pursuant to R.I. Gen. Laws § [23-17.14-12.1](#).

23.10 Reports, Use of Experts, Costs, and Investigations

- A. Engaging the use of experts, receiving reports, and their associated costs during review are pursuant to R.I. Gen. Laws § [23-17.14-13](#).
- B. The conduction of investigations is pursuant to R.I. Gen. Laws § [23-17.14-14](#).

23.11 Limits to Subsequent Acquisitions

Limits to acquisitions are pursuant to R.I. Gen. Laws § 23-17.14-19.

23.12 Concurrent Review

- A. The Director may consider the requirements of the Act and the requirements of R.I. Gen. Laws §§ 23-17-1 through 23-17-45 together upon completion of the initial application. The Director may approve, approve with conditions, or disapprove one or both requests filed pursuant to the Act and R.I. Gen. Laws §§ 23-17-1 through 23-17-45.
- B. The decision of the Director approving or denying a conversion application required by the Act shall be subject to judicial review in accordance with the provisions of R.I. Gen. Laws §§ 42-35-15 and 42-35-16. For any conversion subject to the Act, the Director may combine any hearings required by the Act with any hearings on similar or related matters required by R.I. Gen. Laws §§ 23-17-1 through 23-17-45 and shall consider issues of market share especially as they affect quality, access, and affordability of services.

23.13 Elimination or Reduction in Emergency Department and Primary Care Services

- A. No hospital emergency department or primary care services which existed for at least one (1) year and which significantly serve uninsured or underinsured individuals shall be eliminated or significantly reduced without the prior approval of the Director in accordance with R.I. Gen. Laws § [23-17.14-18](#).
1. Prior to the elimination or significant reduction of an emergency department or primary care services which existed for at least one (1) year, a hospital shall provide the Director a written plan whereby it proposes to do any of the following:
 - a. Eliminate its emergency department;
 - b. Reduce the operation of its emergency department to less than twenty-four (24) hours per day;
 - c. Make material reductions in emergency department staff providing emergency health care services;
 - d. Eliminate the delivery of primary care services;
 - e. Reduce by twenty-five percent (25%) or more its hours of operation for delivery of primary care services (including, but not limited to, family practice, pediatrics, internal medicine, obstetrics/gynecology, or mental health services);
 - f. Make material reductions in the number or qualifications of staff which affects access to or continuity of primary care services; or
 - g. Take other actions which result in a significant reduction in primary care services.
 2. The written plan describing the impact of such proposal and describing the proposed reduction or elimination will be provided to the Director in a form acceptable for review prior to the implementation of the proposed reduction or elimination, as required in § 23.13(A)(1) of this Part, and shall include, at a minimum, the following information:
 - a. A description of the services to be reduced or eliminated;
 - b. The proposed change in hours of operation, if any;
 - c. The proposed changes in staffing, if any;

- d. The documented length of time the services to be reduced or eliminated have been available at the facility;
 - e. The number of patients utilizing those services that are to be reduced or eliminated annually during the most recent three (3) years;
 - f. Aggregate data delineating the insurance status of the individuals served by the facility during the most recent three (3) years;
 - g. Data describing the insurance status of those individuals utilizing those services that are to be reduced or eliminated annually during the most recent three (3) years;
 - h. The geographical area for which the facility provides services;
 - i. Identification and description, including supporting data and statistical analyses, of the impact of the proposed elimination or reduction on:
 - (1) Access to health care services for traditionally underserved populations, including but not limited to, Medicaid, uninsured and underinsured patients, and racial and ethnic minority populations;
 - (2) The delivery of such services on the affected community: emergency and/or primary care in the cities and towns whose residents are regularly served by the hospital (the “affected” cities and towns);
 - (3) Other licensed hospitals or health care providers in the affected community or cities and towns; and,
 - (4) Other licensed hospitals or health care providers in the state; and,
 - j. Such other information as the Director deems necessary.
3. Upon receipt of the completed plan, as described above, in a form acceptable for review, the Director shall determine based upon the public interest in light of attendant circumstances whether the services affected by the proposed elimination or reduction significantly serve uninsured and/or underinsured individuals. If the Director determines that the services affected by the proposed elimination or reduction do significantly serve uninsured and/or underinsured individuals, the written plan shall be

reviewed in accordance with the requirements of § 23.13(A)(4) of this Part below and must be approved by the Director prior to the elimination or reduction of said services.

4. Notwithstanding any other provision in the General Laws, the Director shall have the sole authority to review all plans submitted under this section and the Director shall issue a decision within ninety (90) days from the receipt of the written plan in form and content acceptable for review by the Department or the request shall be deemed approved. If deemed appropriate, the Director may issue public notice and allow a written comment period within sixty (60) days of receipt of the receipt of the proposal.
 - a. If the Director disapproves the proposal within ninety (90) days of receipt of the written plan in a form acceptable for review, he/she shall afford written expressed reason(s) for disapproval.

23.14 Provision of Charity Care, Uncompensated Care, and Community Benefits

- A. All hospitals shall, as a condition of initial and/or continued licensure:
 1. Meet the statewide standards for the provision of charity care as provided in this Part;
 2. Meet the statewide standards for the provision of uncompensated care as provided in this Part;
 3. Meet the statewide standards for the provision of community benefits as provided in this Part;
 4. Not discourage persons who cannot afford to pay from seeking essential medical services; and,
 5. Not encourage persons who cannot afford to pay to seek essential medical services from other providers.
- B. The Director shall, on an annual basis, review each licensed hospital's level of performance in providing charity care and uncompensated care.
- C. The Director shall consider the appropriate amount of charity and uncompensated care necessary to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

23.14.1 Statewide Standards for the Provision of Charity Care

- A. Every licensed hospital shall be in full compliance with the following statewide standards for the provision of charity care:
1. A hospital may expand its financial assistance beyond this Part but it shall not reduce the assistance nor restrict the qualifications further than this Part.
 2. These standards apply to uninsured, low-income Rhode Island residents ineligible for state, federal or employer sponsored health insurance, and shall cover all inpatient and outpatient essential medical services routinely billed by the hospital and provided under the hospital's license, and routinely reimbursed by the Rhode Island Medicaid program(s).
 3. Hospitals shall provide full charity care (i.e., a 100% discount) to patients/guarantors whose annual income is up to and including 200% of the Federal Poverty Levels (FPL), taking into consideration family unit size.
 4. In addition, in order to qualify a patient/guarantor for full charity care (§ 23.14.1(A)(3) of this Part), a hospital may or may not also apply an assets criterion requiring that the patient's/guarantor's assets not exceed the assets protection threshold.
 5. If a hospital applies the assets criterion (§ 23.14.1(A)(4) of this Part) in addition to the income criterion (§ 23.14.1(A)(3) of this Part) in determining eligibility for full charity care only, in cases where a patient/guarantor qualifies for full charity care under the income criterion but does not meet the assets criterion (i.e., has assets in excess of the assets protection threshold), the hospital must provide the patient/guarantor the highest discount offered by the hospital under § 23.14.1(A)(6) of this Part on the whole hospital bill, and the maximum amount that the hospital may pursue for collection shall be the patient/guarantor's actual assets less the assets protection threshold.
 6. Hospitals shall provide partial charity care (i.e., a discount less than 100%) to patients/guarantors whose annual income is between 200% and up to and including 300% of the Federal Poverty Levels (FPLs), taking into consideration family unit size. This partial charity care shall be on a sliding scale discount basis determined by each individual hospital pursuant to its own evaluation of its service area needs and financial resources. For purposes of determining eligibility for partial charity care only, hospitals may or may not also apply the assets criterion under § 23.14.1(A)(4) of

this Part. Should a hospital apply the assets criterion, it has the discretion in how this criterion is evaluated in determining eligibility for partial charity care.

7. Hospitals may deny charity care if the patient/guarantor does not provide the information and documentation necessary to apply for charity care or other existing financial resources that may be available to pay for the healthcare services. If a patient/guarantor is denied charity care, the hospital may place the outstanding account in bad debt status and pursue collections consistent with §§ 23.14.1(A)(14) and 23.14.2 of this Part.
8. The hospital shall provide public 'Notice of Hospital Financial-Aid' on forms provided by the Department. This public Notice shall be approved by the Director, no less than standard 'letter' size (8.5" x 11"), and be prominently posted in Emergency Departments, admission areas, outpatient care areas and on the hospital's website. The hospital shall also make this notice available in other languages in accordance with the applicable provisions of the "Standards for Culturally and Linguistically Appropriate Services in Health Care" incorporated in § 23.2 of this Part.
9. The hospital shall provide that same public 'Notice of Hospital Financial-Aid' on each hospital patient bill. This public notice shall be approved by the Director and may be in a size less than 8.5" x 11".
10. The hospital shall provide its 'Financial-Aid Criteria' on forms provided by the Department for qualifying patients/guarantors for charity care including information on the sliding scale discount schedule for partial charity care under § 23.14.1(A)(6) of this Part. This Financial-Aid Criteria shall be approved by the Director and be made available to all persons on request. The hospital shall also make this Financial-Aid Criteria available in other languages in accordance with the applicable provisions of the "Standards for Culturally and Linguistically Appropriate Services in Health Care" incorporated in § 23.2 of this Part.
11. The hospital shall use a standardized 'Application for Hospital Financial-Aid' on forms provided by the Department or as approved by the Director in determining eligibility for full and partial charity care. With the exception of the deletion of the "Assets" Section on the Application (in cases where the hospital does not apply the assets criterion), any material changes to the Application (additions and/or deletions) must first be approved by the Director.

12. Within fourteen (14) days after receipt of a completed Application for Hospital Financial-Aid, the hospital shall render a decision on charity care and notify the patient/guarantor of its decision in writing.
13. The hospital shall have a timely Appeals Process in place should a patient/guarantor be denied charity care. This appeal process shall be set forth in writing and adopted as formal hospital policy and be made available to all persons on request.
14. The hospital shall have a Collections Process in place with this process set forth in writing and adopted as formal hospital policy, and be made available to all persons on request.
15. The hospital shall provide the Department on an annual basis or as required by the Director information including, but not be limited to:
 - a. The 'Annual Financial-Aid Data Filing' on forms provided by the Department or as determined by the Director;
 - b. The public Notice of Hospital Financial-Aid pursuant to § 23.14.1(A)(8) of this Part;
 - c. A copy of a hospital bill including the public Notice of Hospital Financial-Aid pursuant to § 23.14.1(A)(9) of this part;
 - d. The Financial-Aid Criteria for charity care including full disclosure of the discount schedule for partial charity care and, if applicable, how the assets criterion is evaluated in determining eligibility for partial charity care under § 23.14.1(A)(10) of this Part;
 - e. The Application for Hospital Financial-Aid under § 23.14.1(A)(11) of this Part;
 - f. The hospital's adopted Appeals Process under § 23.14.1(A)(13) of this Part;
 - g. The hospital's adopted Collections Process pursuant to § 23.14.1(A)(14) of this Part.

23.14.2 Statewide Standards for the Provision of Uncompensated Care

- A. The statewide standards for the provision of uncompensated care shall be that the hospital (or its agent(s)) may attach, but shall not force foreclosure of a patient's/guarantor's primary residence for non-payment of amounts owed (bad debt).

1. Hospitals shall report the amounts of Medicaid Shortfalls, Charity Care, and Bad Debt to the Department, as well as other financial information as determined by the Director.

23.14.3 Statewide Standards for the Provision of Community Benefits

- A. The statewide standards for the provision of community benefits shall be full compliance with the following:
 1. Each licensed hospital shall provide on or before March 1st of each calendar year (as practicable), a report in a form acceptable to the Director, a detailed description with supporting documentation, evidence of compliance of this section including, but not limited to, the cost of charity care; bad debt; contracted Medicaid shortfalls; and any additional information demonstrating compliance with this section.
 2. On and after 1 January 2001, each licensed hospital shall have a formal, Board-approved plan for the provision of community benefits. This plan shall be updated and Board-approved, at a minimum, every three (3) years. The plan shall incorporate, at a minimum, the following principles:
 - a. The governing body shall adopt/affirm and make public a community benefits mission statement setting forth the hospital's commitment to a formal community benefits plan;
 - b. The governing body, the chief executive officer, and senior management shall be responsible for the oversight of the development and implementation of the community benefits plan, the methods to be followed, the resources to be allocated, and the mechanism for regular evaluation of the plan on no less than an annual basis;
 - c. The governing body shall delineate the specific community or communities, including racial or ethnic minority populations, that will be the focus of its community benefits plan and shall involve representatives of that designated community or communities in the planning and implementation process;
 - d. The community benefits plan shall include a comprehensive assessment of the health care needs of the identified community or communities, which shall include, but not be limited to, needs related to the goals articulated in A Healthier Rhode Island by 2010: A Plan for Action, as well as a statement of priorities consistent with the hospital's resources; and

- e. The community benefits plan shall specify the actual or planned dates for implementation of the activities and/or proposals included therein.
- B. If the Department receives sufficient information indicating that a licensed hospital is not in compliance with § 23.14 of this Part, the Director shall hold a hearing upon ten (10) days notice to the licensed hospital and shall issue in writing findings and appropriate penalties as set forth in § 23.17 of this Part.

23.15 Gag Rules Prohibited

Gag rules are prohibited pursuant to R.I. Gen. Laws § [23-17.14-16](#).

23.16 Perjury

The penalty for perjury is pursuant to R.I. Gen. Laws § [23-17.14-17](#).

23.17 Failure to Comply

The penalties for failure to comply with this Part will be applied pursuant to R.I. Gen. Laws § 23-17.14-30.

23.18 Whistleblower Protections

Whistleblower protections are pursuant to R.I. Gen. Laws § [23-17.14-29](#).

23.19 Judicial Review

Judicial review is pursuant to R.I. Gen. Laws § 23-17.14-34.

216-RICR-40-10-23

TITLE 216 - DEPARTMENT OF HEALTH

CHAPTER 40 - PROFESSIONAL LICENSING AND FACILITY REGULATION

SUBCHAPTER 10 - FACILITIES REGULATION

PART 23 - Hospital Conversions (216-RICR-40-10-23)

Type of Filing: Amendment

Effective Date: 08/29/2018

Editorial Note: This Part was filed with the Department of State prior to the launch of the Rhode Island Code of Regulations. As a result, this digital copy is presented solely as a reference tool. To obtain a certified copy of this Part, contact the Administrative Records Office at (401) 222-2473.