



RI LTACH Needs Assessment & Site Feasibility Evaluation

Final Report
May 2026

Project Introduction

In 2022, EOHHS set a strategic goal to restore Eleanor Slater Hospital (ESH) to Long Term Acute Care Hospital (LTACH) functionality in a modern facility.

Initial Findings 2023: FCG's initial needs assessment:

- **Total ESH bed need ranged from 85-119** for both hospital level of care & Extended Care Services (ECS)
- **A single hospital license model** would allow ESH to maintain Medicaid cost-based reimbursement and better manage IMD classification risk
- **Expanding to Medicare and commercial markets** would boost referrals but require significant investment & careful management of the ECS population to retain sufficient capacity for hospital level of care patients

Developments:

- **\$108 million was approved** in the SFY 2023 budget for a new LTACH facility on the Zambarano campus, but updated analyses suggest higher costs¹

Project Goal:

To validate the initial assessment and explore a broader range of construction, real estate, and financial model options for an 85–119 bed LTACH facility

- Validate & refine Eleanor Slater Hospital's **LTACH bed need and patient mix**
- Identify and assess **alternative real estate, construction, and financial models**—including options at Zambarano and Cranston campuses, new builds, and reuse of existing facilities²
- Develop **criteria and cost estimates for each alternative**, comparing them to the planned new build
- **Engage stakeholders** to gather feedback on options, criteria, costs, and strengths/weaknesses

Executive Summary of Learnings (page 1 of 2)

Task 1: Needs Assessment

- ❑ **LTACH Facility Size Needed: 91 total beds, including 21 intensive hospital level of care (HLOC) beds and 70 extended hospital care beds.**
 - **Intensive Hospital Level of Care Demand:** An average of 557 potential LTACH eligible patients requiring intensive HLOC are discharged annually from RI acute care hospitals. This equates to a need for ~48 beds statewide, representing a midpoint relative to national benchmarks (30–60 beds) and consistent with market testing conducted with hospitals as part of the 2023 prior study. ESH is projected to capture 40% of the statewide market, resulting in 222 admissions annually at full implementation, translating into 21 intensive HLOC beds.
 - **Extended Hospital Care Services Demand:** As ESH increasingly admits intensive hospital-level LTACH patients, demand for extended care services (ECS) is expected to decline proportionally. However, 5–15% of admissions are projected to require extended care for periods longer than 1 year, translating to a need for 70 Extended Hospital Care Services beds.
- ❑ **Key Determinations of Bed Need:**
 - **Market Share by Payer:** By Year 10, ESH is assumed to secure 90% of Medicaid/Medicare FFS referrals and 75% of Medicare Advantage referrals, with 50% of referrals converting to admissions. This will require dedicated resources and state support.
 - **Extended Hospital Services Length of Stay:** This assumption is the most uncertain and has the greatest impact on projected bed need due to limited historical data. Weighted average LOS for extended hospital stays are projected at 3.7 years.
- ❑ **Necessary Conditions for Success:** Achieving projected utilization requires the State to meet nine necessary conditions, most notably securing Medicare Advantage contracts + sustainably managing risk of becoming an Institute of Mental Disease (IMD census > 50% psych).
- ❑ **Managing IMD Risk:** Becoming an Institute of Mental Disease (IMD Census > 50%) would risk \$60M in federal funds per year. Building the new facility and effectively achieving the admission targets should enable the state to sustainably manage the risk of becoming an Institute of Mental Disease long term; However, interim strategies will be needed to address the risk prior to full implementation.

Executive Summary of Learnings (page 2 of 2)

Task 2: Site and Financial Model Feasibility

- ❑ **Potential LTACH facility locations** were identified in partnership with the Dept of Administration, Division of Capital Asset Management and maintenance (DCAMM) through a screening of state-owned properties, available state-owned buildings, recently vacated private hospital sites, and underutilized privately-owned sites.
- ❑ **A shortlist of six (6) viable site & facility options** were developed that meet baseline program requirements: Zambarano Campus, Pastore Campus, RI Department of Health Laboratory (RIDOHL), Ladd Center, and two private sites (Private Sites 1 & 2)
- ❑ **Total construction costs** across sites range from \$239M for Pastore to \$393M for Private Site 2 (2030 dollars)
- ❑ **Final site decision will likely reflect tradeoff** between patient experience (rural sites)¹ and access, cost efficiency, & implementation feasibility:
 - The Pastore Campus appears most feasible, driven by its strong performance in implementation, cost efficiency, and proximity to demand drivers. RIDOHL offers a strong second option, with less implementation advantages but strong scoring on demand drivers (e.g., proximity to patients, amenities, and the I-95 corridor).
 - While rural sites such as Zambarano and Ladd Center offer superior patient experience, they are constrained by access, infrastructure, and timeline limitations.
 - Privately owned sites provide strong access to patients and workforce but introduce higher costs and greater delivery risk due to acquisition and regulatory complexity.
 - Campus-based sites, particularly Pastore, offer a more streamlined, lower-risk development pathway, while alternative sites may require greater up-front investment and longer timelines to achieve similar outcomes.
- ❑ **Two primary financial model options were assessed:** Traditional Public Bond Financed Delivery and Public-Private Partnership (P3) Delivery
 - Public-Private Partnerships (P3s) are primarily a financing and risk-allocation tool, not a guaranteed efficiency gain. They are most valuable if public capital is constrained.
 - Initial assessment indicates a P3 delivery model may be feasible, however further research into market interest, Medicaid reimbursement and Medicare match allowances, and capital availability/long-term budget impact is required.

Urgency of Action

This study confirmed 2023 findings - a **significant need for LTACH services** in Rhode Island¹

- **Why Action on a New Facility is Urgent**

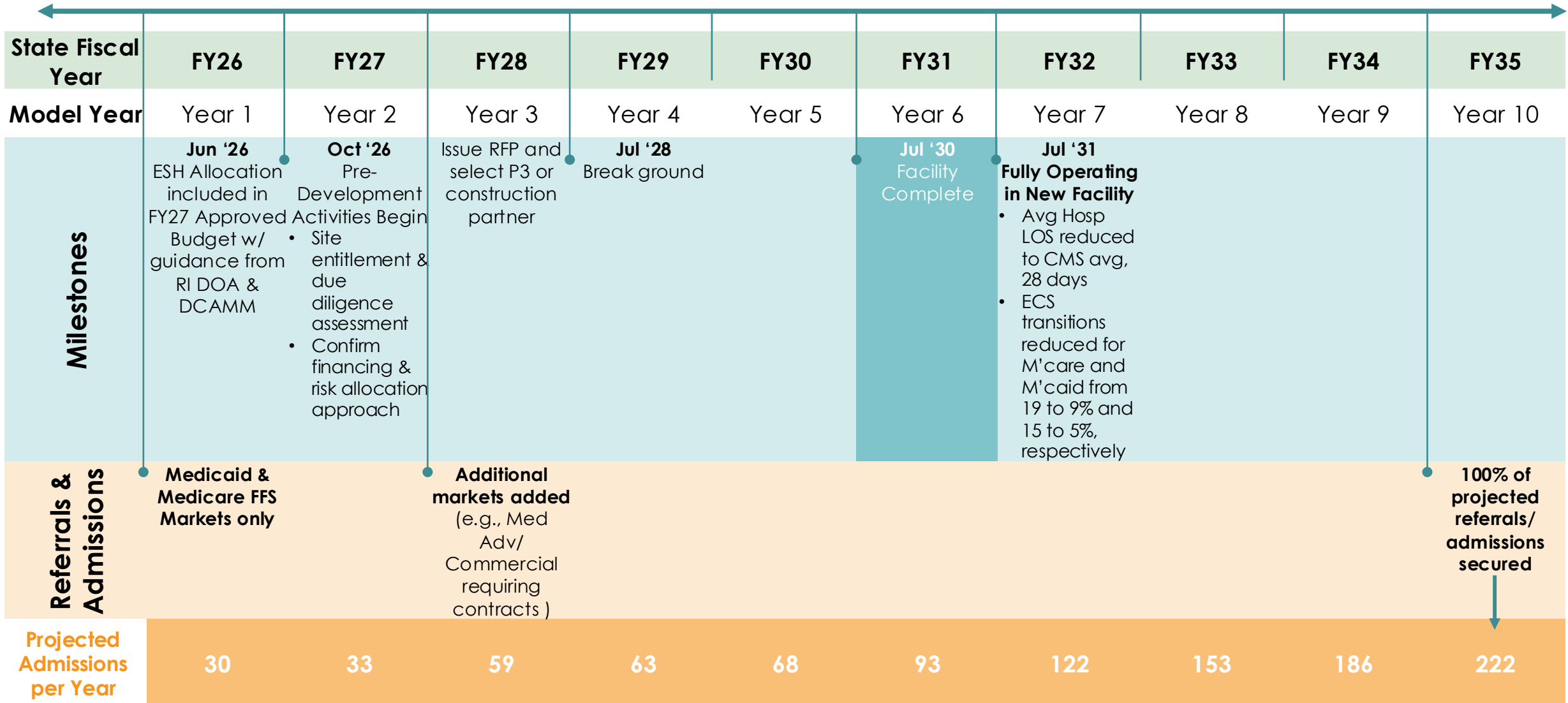
- **Existing facilities cannot support long-term LTACH growth** or reliably balance hospital-level, extended-care, and psychiatric patients.
- **IMD exposure grows** without additional medical capacity, **risking ~\$60M in federal funding** annually.
- **Limited LTACH capacity constrains RI hospital beds** and prolongs stays for medically complex patients.
 - In 2024, RI tied with MA for the third-longest average ER wait time in the U.S.²
- **Prolonged inaction increases financial exposure** and reduces flexibility to respond to patient demand, federal rules, and market conditions.

- **A New Facility Changes ESH's Trajectory by:**

- Providing the **infrastructure platform** required to meet all 2026 Necessary Conditions
- Reducing IMD risk / Improving sustainable IMD management
- Avoiding repeated sunk capital in facilities that cannot support long-term LTACH operations
- Positioning the State to reduce hospital bottlenecks and protect federal and state investment

High-Level ESH Implementation Timeline

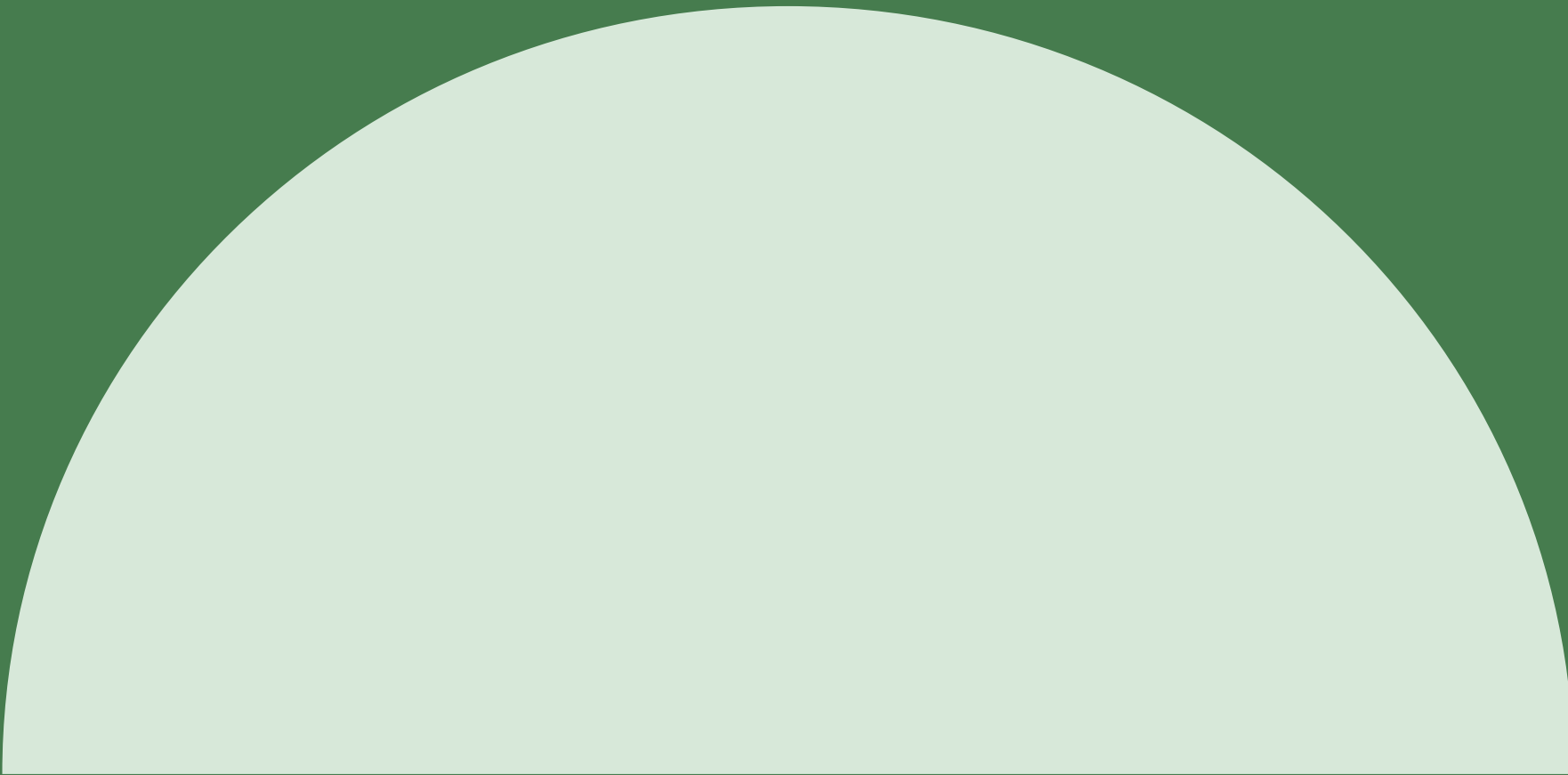
We estimate that the new facility will be fully operational in Year 7 (FY 2032)



Suggested Next Steps

- Pursue recommended immediate/interim strategies to increase complex medical LTACH admissions and actively monitor and manage IMD risk within current building/site
- Confirm LTACH site selection and begin site planning, including final site program & building design
- Begin alternative use assessment and site option review for the Beazley building and Zambarano campus

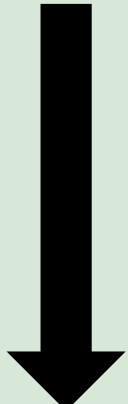
Task 1: Needs Assessment



Bed Need Summary

ESH will require 91 beds total beds assuming key success factors and necessary conditions are met. IMD risk is greatly reduced compared to current state, however an interim risk mitigation strategy is still required.

Target Scenario

<p>Key Sources</p>	<p>Assumptions defined using 1) RI Hospital Discharge Data, 2) Eleanor Slater Hospital experience (FY24-25), & 3) Input from ESH leadership and clinical experts</p>
<p>Key Success Factors</p> 	<p>ESH accomplishes a gradual transition to traditional LTACH operations by:</p> <ol style="list-style-type: none"> Increasing medical LTACH referrals and referral to admission conversion rates by pursuing: <ul style="list-style-type: none"> Expanded specialty service capacity Medicare Advantage contracts Additional venues to educate referral hospitals on ESH Hospital Level Care (HLOC) capacity Dedicated public perception improvement strategies Decreasing intensive hospital level care length of stay (LOS) Decreasing transitions to extended hospital care services (ECS) Decreasing extended hospital care services LOS by: <ul style="list-style-type: none"> Shifting patient profile to more traditional LTACH mix w/ reduced ECS needs Enhancing focus on ECS patient discharge planning via active care management & ID of discharge options for ECS patients <div data-bbox="2076 606 2497 885" style="border: 1px solid black; padding: 5px; margin-top: 20px;"> <p><i>Achieving these key success factors requires the state to accomplish Nine "Necessary Conditions"</i></p> </div>
<p>Total Beds (HLOC/ECS)</p>	<p>Accomplishing the Key Success Factors above and achieving the Nine Necessary Conditions results in the following LTACH bed need for Eleanor Slater</p> <p style="text-align: center;">91 beds 21 HLOC beds / 70 ECS beds</p>
<p>IMD Risk</p>	<p>While multi-year LTACH reforms are underway, ESH faces insufficient non-psychiatric admissions, risking IMD status Building the new facility and achieving the admission targets should enable the state to sustainably manage the risk of becoming an Institute of Mental Disease long term; However, interim strategies will be needed to address the risk prior to full implementation. High Risk ≥50% est from 2029-2032</p>

Bed Need Over Time

Considering an 80% hospital LOC and 90% ECS occupancy rate, **91 facility beds and 21 intensive hospital LOC beds** would be required, given Target Scenario assumptions.

Referral & Admission Assumptions

Universe of Potential Patients	557
Referral Rates: FFS (M'caid & Mcare) / Med Adv / Comm'l	90/75/0%
Conversion Rates	50/50/0%
Annual LTACH Admissions (Fully Implemented)	222

Extended Hospital Care/ECS Assumptions

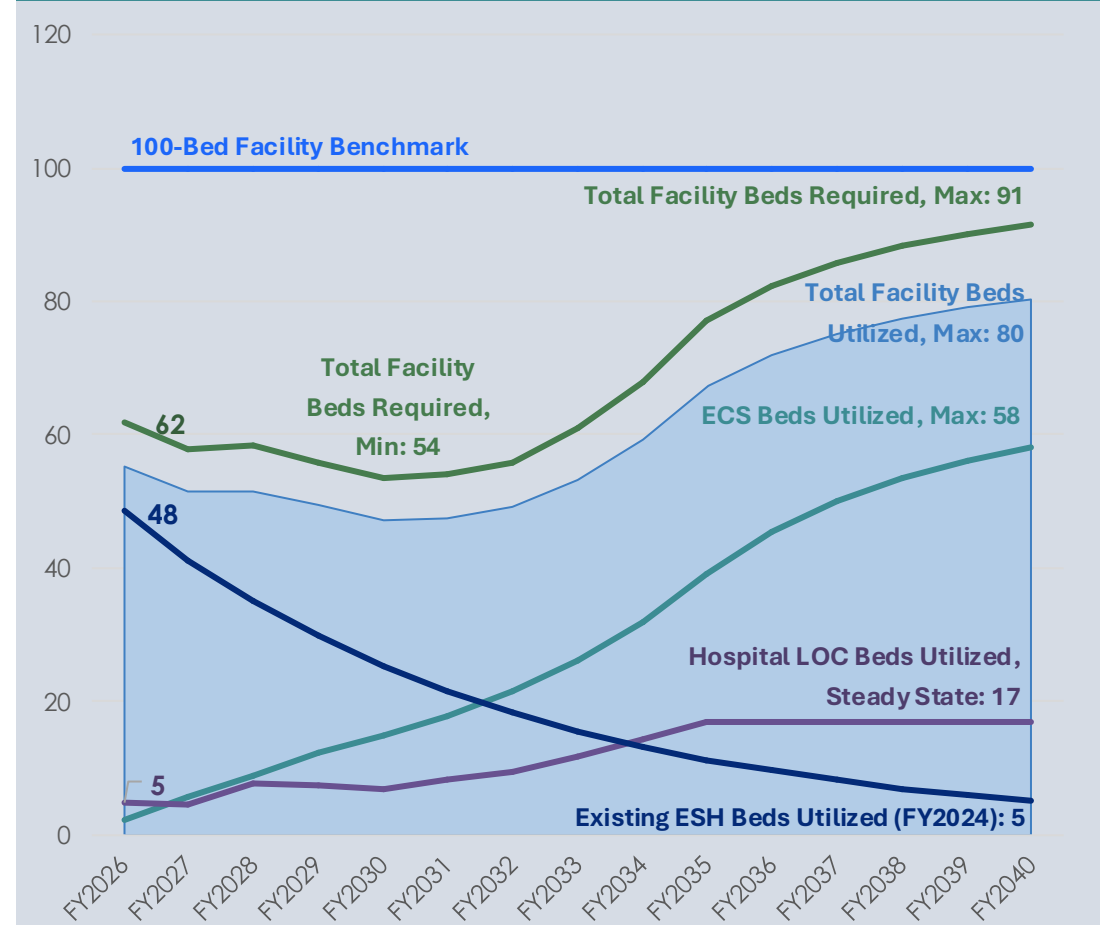
ECS Transition by Payer – Medicare / Medicaid	5 / 15%
ECS Weighted Average Length of Stay ¹	3.7 Years

Summary of Bed Need Over 15 Years Hospital 80% / ECS 90% Occupancy

	Est. Steady State
Intensive Hospital LOC Beds Required	21
Total Facility Beds Required	91

ESH is assumed to secure an increasing share of the Medicaid, Medicare markets over time, thereby increasing hospital LOC beds required. With more “traditional” LTACH admissions and attention to discharge planning, ECS length of stay is assumed to shorten, reducing but not eliminating risk of ECS patients taking over HLOC capacity.

Results: Projected Bed Occupancy & Need Over Time



1. Weighted average ECS length of stay is based on tiered assumptions of LOS (historic ESH data was leveraged in LOS assumptions).

Necessary Conditions

The 2026 update builds on the 2023 Necessary Conditions. These updates refine and align conditions to implementation realities and the current payer mix/regulatory environment. Specifically, we have identified Nine (9) Necessary Conditions as follows:

(1) Care Delivery Readiness

Operational prerequisites that drive patient flow

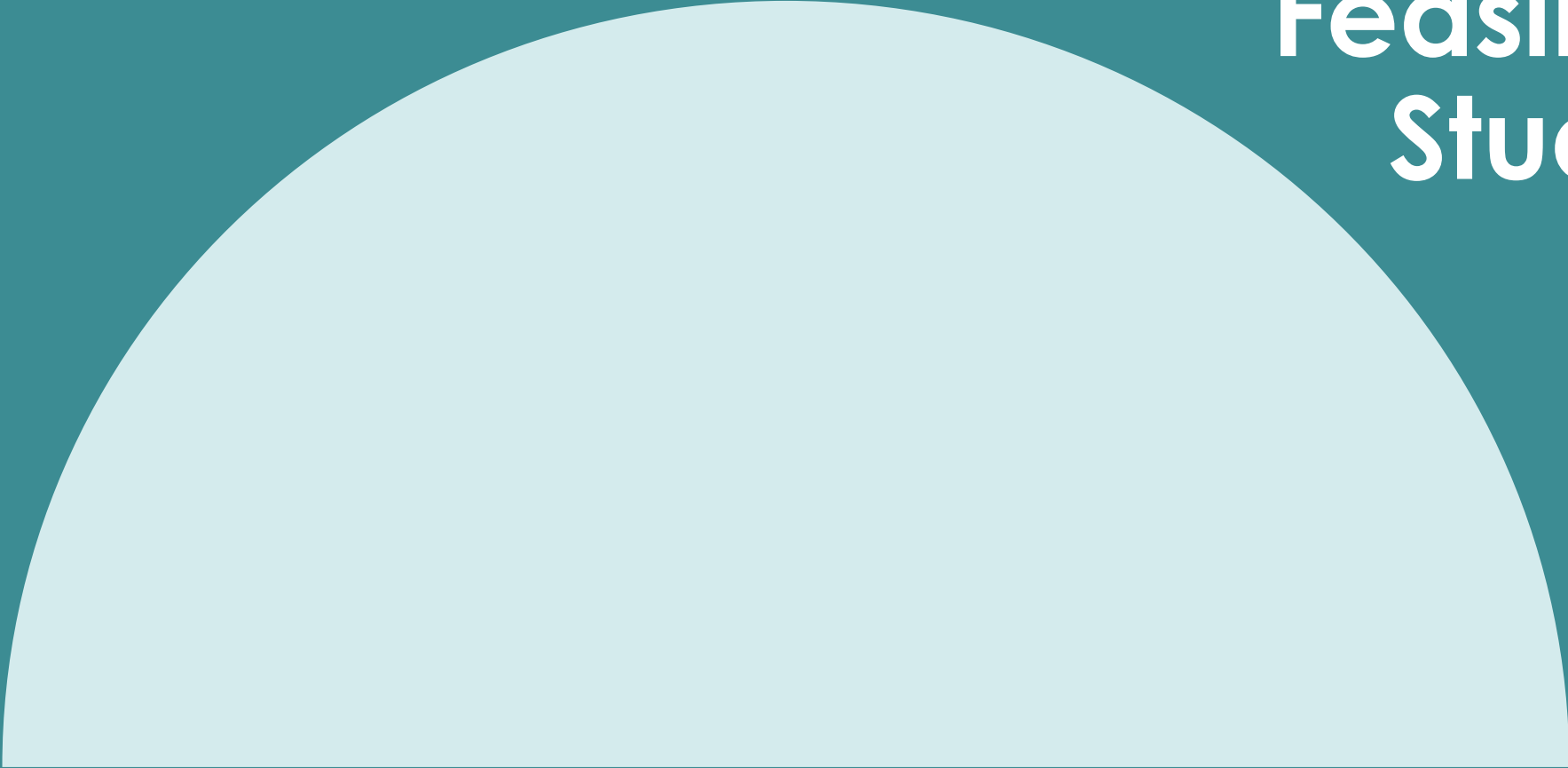
#	2026 Necessary Conditions	Level of Urgency
1	Secure a Sustainable Flow of Hospital-Level Referrals	High
2	Develop Capacity in Several Service Lines	High
3	Monitor Extended Care Patients & Develop Discharge Options	Low
4	Maintain Medicare LTACH Designation	Med

(2) Financial & Federal Sustainability

How the state pays for and protects its investment in care delivery

#	2026 Necessary Conditions	Level of Urgency
5	Sustainably Manage IMD Rule	High
6	Strengthen Medicare Revenue	Med
7	Maintain Medicaid Cost-Based Reimbursement	High
8	Optimizing Available Federal Match	High
9	Reduce Costs to Sustain Operations Under Realistic Payment Rates	High

Note: A Modern LTACH Facility is the foundation from which these Necessary Conditions were developed. It is the infrastructure foundation that enables ESH to deliver required specialty services, strengthen referral relationships, and operate sustainably under applicable regulatory and payment rules.



Task 2: Site & Financial Model Feasibility Study

Screened Sites

- **AECOM developed an initial long list of 17 potential sites**, categorized into four tiers:
 - Tier 1: Existing State-owned campus site
 - Tier 2: Other State-owned sites
 - Tier 3: Underused hospitals
 - Tier 4: Other privately-owned sites
- Through a screening process, **11 sites were removed from further consideration**, listed in the table at right. Five sites were no longer available, three were excluded due to zoning constraints, one was deemed too large relative to the required program, one too small, and one was eliminated due to the presence of an active operating tenant.
- While these constraints were not necessarily prohibitive to development, they introduced additional complexity, cost, and delivery risk relative to the shortlisted sites, making them less competitive for further evaluation relative to the required program.

Rejected Sites	Reason for Rejection
Memorial Hospital of Rhode Island*	Too large
Saint Joseph Hospital for Specialty Care	No longer available
Route 295 & Route 7 Site	No longer available
Private Site 3	No longer available
Private Site 4	Zoning constraints
Private Site 5	Zoning constraints
Private Site 6	Zoning constraints
Private Site 7	Too small
Private Site 8	Active operating tenant
Private Site 9	No longer available
Private Site 10	No longer available

* Memorial Hospital was acquired by the City of Pawtucket in recent weeks for redevelopment. While uncertain, this change in ownership could move this site back into consideration.

Final Sites for Evaluation

- **The resulting shortlist includes six sites**, summarized in the table below. These sites represent the most feasible and competitive options following initial screening, balancing program fit, implementation complexity, and proximity to demand.
- The shortlist includes a mix of State-owned campuses, institutional facilities, and privately owned sites. The sites are distributed across the state, with a concentration in the Providence metro area and select options in more rural locations.
- Additional detail on the State-owned site options and potential building configurations is provided in the following slides.
- Private sites are not disclosed at this juncture, reflective of the potential need for future land and building acquisition if these sites were to be purchased for an LTACH.
- The project team has not contacted private property owners during this process.

Potential Site Locations

1	Zambarano Campus
2	Pastore Campus
3	Ladd Center
4	RI Department of Health Laboratory (RIDOHL)
5	Private Site 1
6	Private Site 2



Source: AECOM

Construction Cost Implications

- The table summarizes estimated vertical construction costs, on-site infrastructure and demolition costs, and total project cost (TPC) (escalated to 2030 dollars) for the shortlisted sites, listed from least to most costly. The analysis is tied to assumptions discussed in the body of this report.
- Pastore Campus is the least costly option overall, with total construction costs estimated between \$239 million and \$243 million, which is in part reflective of specific shared services opportunities which decrease the required space program. RIDOHL and Ladd Center are the second least costly options at approx. \$292 million.
- Zambarano Campus is the most expensive State-owned site, with total construction costs estimated at \$322 million, which is largely a reflection of horizontal and off-site infrastructure needs which are unique to this campus. This cost does not include a parallel state project to demolish several vacant buildings on the campus.
- Privately owned sites are anticipated to be more costly than State-owned sites, driven largely by expectations for land acquisition costs.
- Private Site 2 is the most expensive overall, at \$393 million, reflecting anticipated downtown Providence real estate premiums.
- The identified private sites are intended to illustrate likely conditions for potential development opportunities across the State that could support an LTACH, rather than to represent an exhaustive list of viable private options.

	Total Project Costs <i>(Escalated to 2030 dollars)</i>
Pastore Campus	\$239M - \$243M
RI Department of Health Laboratory (RIDOHL)	\$292M
Ladd Center	\$291M - \$294M
Zambarano Campus*	\$322M
Private Site 1	\$326M - \$329M
Private Site 2	\$393M

* Zambarano cost estimate includes \$26M in specialty utility support costs based on the December 2025 Canon Design Development Project Budget

Evaluation Criteria Methodology

- A structured evaluation framework was developed to assess each site consistently across four key criteria: space needs, patient experience, implementation feasibility, and proximity to demand drivers.
- Each evaluation factor was assigned a relative weight to reflect its importance in the overall site selection process, with greater emphasis placed on space needs and patient experience.
- Sites were scored on a standardized scale of 1 to 3 for each factor, with higher scores indicating more favorable conditions. Weighted scores were calculated by applying the assigned weights to each factor.
- The maximum possible weighted score is 36, and total scores were used to rank sites and identify the most competitive options.
- Construction costs, development timelines, and potential for alternative financing were evaluated separately and not incorporated into the scoring matrix but were considered alongside scoring results in the overall assessment.

	Weight	Scoring (1-3)
Space Needs		
Meets min. space requirements	3	1 = Does not meet SF requirements; 3 = Meets or exceeds SF requirements
Patient Experience		
Patient experience	2	1 = Lower quality patient experience; 2 = Moderate quality patient experience; 3 = High quality patient experience
Implementation		
Operational efficiencies	2	1 = No shared-use potential; 2 = Some shared-use potential; 3 = High shared-use potential
Demand Drivers		
Proximity to LTACH patients	1	1 = Greater than a 30-minute drive of the mean center; 2 = Within a 30-minute drive; 3 = Within a 15-minute drive
Nearby employee concentration	1	1 = Greater than a 30-minute drive of the mean center; 2 = Within a 30-minute drive; 3 = Within a 15-minute drive
Access to public transit	1	1 = Beyond 1/2-mile from a RIPTA bus stop; 3 = Within 1/2-mile of a RIPTA bus stop
Access to the I-95 corridor	1	1 = Greater than 10 miles from the corridor; 2 = Within 10 miles of the corridor; 3 = Within 3 miles of the corridor
Proximity to amenities	1	1 = No amenities within a 10-minute drive; 3 = Amenities within a 10-minute drive

Scoring Results

- The table below summarizes each site's performance across the evaluation criteria. Pastore Campus ranks highest overall, with a weighted score of 31, driven by strong performance in implementation and proximity to demand drivers.
- All sites meet minimum programmatic space requirements and receive the maximum weighted score for this factor.
- Zambarano Campus and Ladd Center score highest inpatient experience, reflecting their rural settings with greater access to outdoor space and lower noise exposure.
- Pastore performs best in implementation due to operational efficiencies and shared-use potential within the existing campus.
- Pastore, RIDOHL, and the privately owned sites score highest in proximity to demand drivers, based in part on proximity to the I-95 corridor.
- Overall, rural sites offer stronger patient experience, while urban and campus-based sites provide better access to patients, workforce, and infrastructure, supporting more efficient and feasible implementation.

	Unweighted Score					Weighted Score				
	Space Needs	Patient Experience	Implementation	Demand Drivers	Total	Space Needs	Patient Experience (2x)	Implementation (2x)	Demand Drivers (1x)	Total
Pastore Campus	3	1	3	14	21	9	2	6	14	31
Private Site 1	3	1	1	15	20	9	2	2	15	28
RIDOHL	3	1	1	14	19	9	2	2	14	27
Private Site 2	3	1	1	14	19	9	2	2	14	27
Zambarano Campus	3	3	2	5	13	9	6	4	5	24
Ladd Center	3	2	1	7	13	9	4	2	7	22

* Higher scores are more desirable
Maximum Weighted Score: 36

Construction Cost Comparison

- The table below outlines estimated construction cost estimates for each site.
- State-owned campus options, particularly Pastore, represent generally lower-cost alternatives**
- Privately-owned sites are in general expected to be more expensive due to land acquisition costs
- The identified private sites are intended to illustrate likely conditions for potential development opportunities across the State that could support an LTACH, rather than to represent an exhaustive list of viable private options.

Site	Zambarano Campus	Pastore Option 1	Pastore Option 2	Ladd Center Option 1	Ladd Center Option 2	RIDOHL	Private Site 1 Option 1	Private Site 1 Option 2	Private Site 2
Core Program	158,346 SF at \$936/SF	129,898 SF at \$930/SF	129,903 SF at \$947/SF	158,346 SF at \$915/SF	158,338 SF at \$924/SF	150,715 SF at \$943/SF	158,346 SF at \$911/SF	158,346 SF at \$919/SF	158,346 SF at \$943/SF
Construction	\$148,200,000	\$120,800,000	\$123,000,000	\$144,900,000	\$146,300,000	\$148,900,000	\$144,200,000	\$145,500,000	\$149,300,000
Professional Services	\$28,150,000	\$22,950,000	\$23,360,000	\$27,550,000	\$27,800,000	\$26,980,000	\$27,430,000	\$27,660,000	\$28,360,000
Furnished Equipment	\$17,100,000	\$14,030,000	\$14,030,000	\$17,100,000	\$17,100,000	\$16,270,000	\$17,100,000	\$17,100,000	\$17,100,000
Fees & Assessments	\$18,002,000	\$15,618,000	\$15,791,000	\$17,733,000	\$17,844,000	\$17,461,000	\$15,270,000	\$15,360,000	\$15,610,000
Land Acquisition	None	None	None	None	None	None	\$35,350,000	\$35,350,000	\$76,560,000
Demo & Site Clearance	Separate Project	\$1,900,000	\$1,900,000	\$3,000,000	\$3,000,000	\$2,300,000	\$1,900,000	\$2,100,000	\$5,800,000
Other Special Costs ¹	\$26,000,000	None	None	\$3,500,000	\$3,500,000	None	None	None	None
Contingencies ²	\$27,430,000	\$21,450,000	\$21,820,000	\$25,900,000	\$26,140,000	\$26,320,000	\$27,200,000	\$27,430,000	\$30,310,000
TPC (2026)	\$264,882,000	\$196,748,000	\$199,901,000	\$239,683,000	\$241,684,000	\$238,231,000	\$268,450,000	\$270,500,000	\$323,040,000
TPC (Escalated to 2030)	\$321,962,000	\$239,148,000	\$242,918,000	\$291,333,000	\$293,764,000	\$291,752,000	\$326,300,000	\$328,790,000	\$392,660,000

- Zambarano cost estimate includes \$26M in specialty utility support costs based on the December 2025 Canon Design Development Project Budget
- Construction + Project Contingencies

Construction Cost Assumptions

Assumptions

- All cost estimates have been rounded to thousands; while resulting total costs will vary slightly from cost estimates in the Appendix, unit cost assumptions are consistent; totals will not add due to rounding.
- The cost estimates include contingencies, not outlined in the previous slide but outlined in the Appendix.
- Land costs are estimated based on prevailing land values in Downtown Providence.
- Potential costs for Phase I environmental due diligence studies and remediation have not been included in all scenarios
- Potential costs to resolve sub-surface conditions are not included.
- Furniture, Fixtures, & Equipment (FF&E) are estimated at \$45.00/SF based on total BGSF.
- For privately owned vacant sites, acquisition cost of \$150/SF assumed. This figure reflects the average sale price per square foot from comparable transactions over the past five years, with a 20% premium applied to account for an “unwilling sale.”
- For privately owned improved sites, acquisition cost of \$350/SF assumed. This figure reflects the average sale price per square foot from comparable transactions over the past five years, with a 20% premium applied to account for an “unwilling sale.”
- Design and Engineering fee of 10% of hard construction costs assumed.
- TPC (Escalated) reflects total project cost escalated to the assumed year of construction.

Why Are Public-Private Partnerships (P3s) Used?

Four Areas of Risks Present in a Project that Can Be Offset on a Private Partner

Pre-Development

Design & Construction

Financing

Operation & Maintenance

Benefits of Public-Private Partnerships

Expanded Development Capacities

- More specialized skills / expertise
- More efficient project delivery process (on-time and within-budget performances)
- Deeper pockets in terms of investment capacities
- Ability for larger scale developments and wider impacts due to breadth of expertise/funding
- Skilled property management teams

Transferred Risks

- Transfer of control of project design/vision onto Private Partner
- Public Partners are disconnected from uncertainties about project delivery/financial performance
- Less financial commitment for Public Partners or impact on credit rating
- Lighter burdens resulted from the management and operation of facilities for Public Partners

Additional Considerations

- The State of Rhode Island has successfully implemented P3 projects in the past.
- However, execution of a P3 is complex and resource-intensive. The process requires a well-structured agreement and RFQ process, and significant upfront effort, coordination, and market engagement.
- Market interest is untested and not guaranteed. Strict requirements for labor, operations, and risk allocation could deter developers entirely; market sounding is critical before pursuing procurement.
- P3 delivery advantages are not guaranteed for LTACHs. Limited and non-diversified revenue streams reduce private sector upside.
- Federal reimbursement introduces additional financial risk. CMS rules on cost reporting, depreciation, and lease structures are complex.

Preliminary Illustrative P3 Annual Cost Projections

The following annual lease estimates are for the purposes of showing order of magnitude capital required to finance a construction project of this scale.

As shown below if the state is able to reserve \$70M in capital to support a P3, estimates suggest an annual lease payment of approx. \$16M; absent upfront funding annual payment increases to \$23M (~44% increase)

Illustrative projections are based on RIDOHL site project cost estimates

	WITH Upfront Capital	WITHOUT Upfront Capital
State Capital – Not Financed	\$70M	\$0
Key Assumptions	6% Interest / 10% Construction Loan / 15% Equity	
Annual Lease Payment (All Funds)	\$16M	\$23M (+44% increase)
Lease Term	Y5 – Y39 / 35 Year Lease	

Considerations

- While this table suggests securing upfront capital would provide significant advantages via a lower annual lease payment, further research is needed to confirm Medicaid reimbursement and Medicare match allowances
- Initial assessments suggest federal rules may cap matchable lease payments in this type of financing arrangement

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