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L. EDWARD BRYANT, JR.
NATIONAL HEALTH LAW
TRANSACTIONAL COMPETITION

OFFICIAL PROBLEM

Introduction

Welcome to the 2026 National Health Law Transactional Competition!

This year, your firm is retained as legal counsel for CuraLink Management Services Organization LLC (“CuraLink”), a dynamic health management services organization based in the state of Loyola. CuraLink has positioned itself at the forefront of integrating specialty care for gastrointestinal (“GI”) cancers and autoimmune diseases, serving independent physician groups across its home state and beyond. With innovation and a passionate drive to improve patient outcomes, CuraLink is on the cusp of another transformative deal—one that could reshape the landscape of specialty GI and autoimmune care.

Background

CuraLink

CuraLink provides management and operational support to seven (7) independent physician group practices that specialize in the treatment, prevention, and management of GI cancers and autoimmune diseases. CuraLink’s principal business model is to coordinate centralized non-clinical organizational tasks, such as information technology (“IT”), electronic medical records (“EMR”), telehealth, supplier contracting, payor negotiations, and daily office and human resources support, for its affiliated practices. CuraLink itself owns the non-clinical assets used by these physician groups—such as real estate interests, administrative office facilities, IT and EMR systems, staff infrastructure (including the systems and processes that support human resources and administrative functions), and contractual supplier relationships. Clinical assets, including medical and diagnostic equipment, are generally individually owned by each physician practice. CuraLink generally leases non-clinical assets to its affiliated practices and manages service agreements, with compensation based on aggregate practice revenue. By centralizing supplier negotiations and payor contracts, CuraLink achieves notable economies of scale and leverages considerable purchasing power, which translates into favorable pricing with vendors and competitive reimbursement from both public and private payors. This collaborative integration model has rendered CuraLink an efficiency leader, supporting high clinical quality and operational profitability across its network.

Recognizing new market opportunities, CuraLink’s leadership now seeks to expand operations to include another high-performing practice group—GI Nexus Specialists PLLC (“GI Nexus”), a prominent physician group practice based outside Loyola, in the neighboring state of Caduceus.

GI Nexus

GI Nexus is a multi-physician specialty group devoted to GI cancers and autoimmune disease care, distinguished for its advanced imaging and radiation facilities, strong clinical ratings, and comprehensive laboratory and telehealth capabilities. The practice fully owns all of its clinical assets—most notably, sophisticated X-ray and radiation equipments—and maintains all required licenses and certifications. GI Nexus owns office and administrative assets, IT infrastructure, and maintains a portfolio of supplier, payor, and hospital contracts. One key contractual and equity relationship is with Saint Raphael Regional Medical Center (“Saint Raphael”), a respected nonprofit hospital which holds a thirty percent (30%) equity interest in GI Nexus and, per the affiliation agreement, requires that GI Nexus provide a set minimum volume of charity care to

underserved populations, alongside developing and maintaining an ongoing patient assistance program.

GI Nexus features ten (10) physician owners who refer patients—often those originating at Saint Raphael—for specialty services, frequently including diagnostic imaging and radiation. These internal referral patterns are an important source of business for GI Nexus. GI Nexus’s charity care obligations are fulfilled annually, but hospital leaders have at times questioned its reporting and outreach efforts. In particular, Saint Raphael has sent two written inquiries in the past eighteen (18) months requesting clarification on charity care patient counts and supporting documentation. These communications indicate concerns regarding potential mission misalignment, underperformance, or deficiencies in communication and reporting related to charitable goals. Since Saint Raphael maintains a direct equity stake and appoints two (2) out of five (5) members to the Board—with both directors’ affirmative votes required for any major transaction—and given that the physician owners routinely refer patients to their own practice’s designated health services, it is crucial for GI Nexus to preserve this vital flow of patients for both clinical care and charitable initiatives. Ensuring that these referral pathways and patient engagement remain intact is an important consideration for GI Nexus to participate in any major transaction.

Recently, GI Nexus experienced two (2) significant regulatory issues. First, a health data breach occurred a week ago that exposed sensitive electronic medical records for several hundred patients due to a failure in remote access protocols. The breach was picked up by local news outlets and quickly reported across public media channels, bringing unexpected public attention to GI Nexus. Second, in response to ongoing staff shortages, the nurse manager directed medical assistants to take on tasks typically performed by licensed nursing staff. This approach was noted during a recent inspection by the Board of Nursing of Caduceus, which has subsequently requested additional details regarding the specific roles and responsibilities assigned to medical assistants within the practice.

CuraLink is particularly interested in GI Nexus for several reasons. First, GI Nexus offers advanced clinical equipment and maintains exceptional clinical quality ratings, significantly surpassing other practices in the region. Second, its integrated charity care program aligns strategically with CuraLink’s broader commitment to social impact. Third, GI Nexus’s strong geographic presence would expand CuraLink’s brand into new territory and serve as a clinical hub, facilitating the efficient sharing of high-value equipment among all seven (7) practice groups within the network.

As legal counsel, your task is to advise CuraLink on the optimal transaction structure for affiliating with GI Nexus in a way that best supports CuraLink’s strategic, legal, and operational goals, as further described below. Consider and assess the available options, then provide a reasoned recommendation based on your analysis.

In addition to complying with all federal laws and regulations, the proposed transaction must comply with relevant state laws, including:

- **Corporate Practice of Medicine (“CPOM”):** Loyola restricts non-physician entities from employing physicians or owning clinical assets, but allows certain exceptions—such as “friendly physician” arrangements, joint ventures with minority ownership—as long as

licensed physicians retain clinical control. In contrast, Caduceus generally limits ownership and control of clinical assets strictly to physicians or physician-owned entities, with only very narrow exceptions that may permit non-physician entities to hold an indirect financial interest, and still require that clinical decisions remain entirely with physicians.

- **Health Data Privacy:** All covered entities in Caduceus must safeguard patient health information, promptly report data breaches to affected patients and the Health Department within ten (10) business days of discovery, and take immediate action to mitigate any improper access. For breaches involving more than one hundred (100) patient records, entities are additionally required to offer complimentary credit monitoring services to affected individuals for at least one (1) year.
- **Change of Ownership Requirements for Facility and Clinical Asset Licenses:** In Caduceus, any direct or indirect change in ownership of a healthcare facility (e.g., hospital, pharmacy, etc.) or its clinically regulated assets (e.g., X-ray or MRI machines) must be reported to the state department of health at least sixty (60) days before closing. Required filings include an application detailing the anticipated post-transaction ownership structure, key personnel information, operational changes, and disclosure of any prior disciplinary actions related to the facility or incoming owners. The department reviews the submission to ensure uninterrupted patient care, confirm new owner qualifications, and assess any potential adverse impacts on patient access or service quality. The department may request additional information before approval to address specific regulatory or compliance concerns.

Assistance Required

CuraLink requests your expert legal, strategic, and operational counsel in deciding whether to proceed with a transaction with GI Nexus. Prepare a memorandum response of no more than twenty-five (25) double-spaced pages that responds to the following prompts:

1. **Regulatory Risks:** Analyze the regulatory risks associated with each transaction structure, including pre- and post-transaction exposure under the CPOM doctrine in both states, HIPAA/data breach liability, scope-of-practice violations, change of licensure or ownership filings, and risks under the anti-kickback and Stark laws. Propose strategies and solutions to address or mitigate these risks.
2. **Potential Liabilities:** Identify and evaluate potential liabilities that CuraLink may inherit through each affiliation option, and recommend approaches for addressing or allocating these risks during the structuring and implementation phase.
3. **Informational Gaps and Due Diligence Needs:** Identify key missing facts or information that could affect your recommendation, and discuss how unresolved or unknown factors may alter your analysis and advice. Provide prioritized recommendations for supplemental due diligence (distinguishing between high and low priority items) and articulating objectives for each diligence request.

4. **Analysis and Final Recommendation:** Present the pros and cons of each strategic option – including, but not limited to, asset purchase (clinical and/or non-clinical), equity acquisition, joint venture, or MSO service affiliation with GI Nexus - and deliver an ultimate recommendation for CuraLink’s path forward, with rationale based on legal, operational, and business factors.

Transactional Memorandum

CuraLink Management Services Organization LLC



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I. Executive Summary

CuraLink Management Services Organization LLC (“CuraLink”) should pursue a two-phase “Turnaround + Earn-In” transaction with GI Nexus Specialists PLLC (“GI Nexus”), built on an immediate, remediation-focused MSO affiliation and a later option to purchase defined non-clinical assets upon meeting key compliance and operational milestones.

In Phase One, CuraLink would enter into an expanded, time-boxed Management Services Agreement and Turnaround Services Agreement giving it immediate control over non-clinical operations, including Information Technology (“IT”) and cybersecurity, Electronic Medical Record (“EMR”) governance, Human Resources (“HR”) and staffing, vendor and payor contracting, billing and collections, and compliance remediation, under a fee structure grounded in fair market value and objective, non-referral-based performance incentives, which aligns with Caduceus’ strict Corporate Practice of Medicine doctrine by preserving physician control over clinical decisions and assets while minimizing successor-liability, change-of-ownership, and Stark Law/Anti-Kickback Statute risks that burden equity, clinical asset purchases, or a joint venture.

In Phase Two, CuraLink’s economics under the MSA would step up once predefined remediation and performance milestones are achieved, and CuraLink would gain an option to purchase a pool of GI Nexus’s non-clinical assets at a future, independently appraised fair market value, with post-exercise leasing or integration of those assets into CuraLink’s platform; a carefully drafted tri-party mission and compliance covenant with GI Nexus and St. Raphael would lock in charity-care and mission protections, clarify consent rights, and convert St. Raphael from a veto-holder into an aligned stakeholder, creating a repeatable, de-risked model for distressed affiliations in Caduceus.

II. Background

A. Regulatory Landscape

To engage in informed dealings with GI Nexus, it is critical to understand the regulatory risks associated with certain transaction structures. The following section lays the foundation for the state and federal regulations that may apply to potential deal structures between CuraLink and GI Nexus.

1. Corporate Practice of Medicine

The Corporate Practice of Medicine (CPOM) generally prohibits non-licensed medical professionals from owning medical or medical-adjacent practices, purchasing clinical assets, or exercising control over clinical decision-making. The state of Loyola permits limited “friendly physician” arrangements and joint ventures with minority ownership as long as licensed physicians retain clinical control. However, Caduceus strictly limits ownership and control of clinical assets to physicians or physician-owned entities and requires full physician clinical control.

2. Healthcare Fraud and Abuse

Because the potential transactions involve ongoing physician referrals, management compensation, equity allocation, and potential ownership of healthcare-related assets, both the federal Anti-Kickback Statute¹ (“AKS”) and the Physician Self-Referral Law² (“Stark Law”), as well as other corollary regulations, will likely be of concern in any transaction between CuraLink and GI Nexus.

Anti-Kickback Statute. The AKS prohibits knowingly and willfully offering, paying, soliciting, or receiving any remuneration to induce or reward referrals for items or services

¹ 42 U.S.C. § 1320a-7b(b).

² 42 U.S.C. § 1395nn.

reimbursable by federal healthcare programs. Remunerations include management fees, equity returns, purchase price adjustments, and any financial benefit tied to referral flow.

Stark Law. The Stark Law is a strict liability statute that prohibits physicians from referring patients for Designated Health Services (“DHS”) payable by Medicare/Medicaid to entities with which the physician has a financial relationship (ownership or compensation), unless a statutory exception applies.

False Claims Statutes. Stark and AKS violations can satisfy the “falsity” elements of the Federal False Claims Act³ and Federal Healthcare False Claims Act⁴ when healthcare providers submit claims for federal healthcare reimbursement that are in violation of either law. Violations of either False Claim Statute can subject the healthcare entity to additional criminal liability.⁵

3. Health Privacy

Regardless of the deal structure, there are regulatory concerns with respect to GI Nexus’s health privacy violations. The governing authority is found in the Health Insurance Portability and Accountability Act of 1996, as amended⁶ (“HIPAA”) and Caduceus state law.

HIPAA. Under HIPAA, covered entities and their business associates are required to protect the privacy and security of patients’ Protected Health Information (“PHI”) by limiting its use and disclosure to treatment, payment, and healthcare operations (unless the patient or its representative authorizes disclosure), implementing safeguards for electronic PHI, entering into Business Associate Agreements when third parties (such as Management Services Organizations or Information Technology vendors) has access to patient data, and providing timely breach

³31 U.S.C. §§ 3729–3733 (2024).

⁴42 U.S.C. § 1320a-7b(a) (2024).

⁵See e.g. 18 U.S.C. § 1341 (2024) (mail fraud), 18 U.S.C. § 1343 (2024) (wire fraud), 18 U.S.C. §287 (2024) (false or fraudulent Claims), 18 U.S.C. §1001 (2024) (false statements or representations), 18 U.S.C. §1956-57 (2024) (money laundering), and 18 U.S.C. §1961 (RICO), and 18 U.S.C. §371 (2024) (conspiracy).

⁶ 42 U.S.C. §§ 1320d et seq.; 45 C.F.R. Parts 160 and 164.

notifications to affected individuals and regulators in the event of unauthorized access, disclosure, or data breaches. HIPAA provides the federally mandated minimum protections for PHI, and states, such as Caduceus, often have stricter requirements.

Caduceus Law. In addition to HIPAA's federal mandates, Caduceus requires that all Covered Entities in the state safeguard PHI, promptly report data breaches to affected patients and the Health Department within ten business days of discovery, and take immediate action to mitigate any improper access. For breaches involving more than 100 patient records, entities are also required to offer free credit monitoring services to affected individuals for at least one year.

4. Scope of Nursing Practice

Each state has its own laws and regulations regarding the scope of nursing practice within the state.⁷ Caduceus's Nurse Practice Act and Board of Nursing ultimately determine what falls within a nurse's scope of practice by issuing licenses, interpreting regulations, and seeking disciplinary actions for any violations.

5. Change in Ownership

Under Caduceus law, any direct or indirect change in ownership of a healthcare facility or its clinical assets must be reported to the Health Department at least 60 days prior to closing. An application listing the anticipated post-transaction ownership structure, key personnel information, operational changes, and disclosure of any prior disciplinary actions must be included in the required filing. If the Health Department is concerned with interruptions to patient care, new owner qualifications, restrictions to patient access, or service quality, the new owners may need to submit additional information before receiving approval.

⁷American Nurses Ass'n, State Law and Regulation, NursingWorld, <https://www.nursingworld.org/practice-policy/state-law-and-regulation/> (last visited Feb. 18, 2026).

6. Antitrust

Substantial business-to-business transactions must comply with federal antitrust regulations. Sections 1 and 2 of the Sherman Act prohibit anticompetitive agreements and monopolization or attempts to monopolize a market, respectively.⁸ Section 7 of the Clayton Act focuses specifically on mergers and acquisitions, prohibiting transactions that “may be substantially to lessen competition” or tend to create a monopoly.⁹ The Federal Trade Commission (“FTC”) Act simply bans “unfair methods of competition”.¹⁰ Lastly, the Hart-Scott-Rodino (“HSR”) Act requires certain large mergers and acquisitions to be reported to the FTC and Department of Justice, subject to regulatory approval.¹¹

B. Legacy Liabilities

1. Successor Liability

CuraLink could be forced to fund remediation related to GI Nexus’s recent data breach and its scope-of-practice violation if GI Nexus is unable to fund it on its own. GI Nexus failed to adequately secure patients’ health records, leading to breaches of Caduceus’ privacy laws and negative media coverage. We do not know what penalties GI Nexus will face for the violations. They could be minimal, like a small fine, or more severe, such as a class action or exclusion from federal programs.

2. Exclusion from Federal Programs

CuraLink may be excluded from Medicare, Medicaid, or other federal programs due to its affiliation with GI Nexus. Exclusion from federal programs by the Office of the Inspector

⁸Sherman Act §§ 1–2, 15 U.S.C. §§ 1–2.

⁹Clayton Act § 7, 15 U.S.C. § 18.

¹⁰Federal Trade Commission Act § 5, 15 U.S.C. § 45.

¹¹Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. § 18a.

General (“OIG”) is an administrative penalty for regulatory violations.¹² If GI Nexus is prevented from benefiting from these programs, CuraLink may face similar penalties if it acquires assets from GI Nexus. This would prevent CuraLink from receiving payment for the services it renders to people who benefit from these programs.

3. Criminal Liability

CuraLink could face criminal and regulatory penalties if it violates Caduceus’s Corporate Practice of Medicine laws. The state of Caduceus prohibits non-physician entities from owning or controlling clinical assets, with very narrow exceptions. Only a physician or a physician-owned entity can own or control clinical assets, so CuraLink could be criminally liable for violating this restriction.

4. Piercing the Corporate Veil

Under the right circumstances, a creditor of GI Nexus could pierce the corporate veil and hold CuraLink liable for its debts. Veil piercing may occur if CuraLink exercises significant control over the joint venture, fails to maintain corporate separateness, commingles assets, or fails to adequately capitalize the asset. In such circumstances, a court may conclude that the joint venture is merely an alter ego of CuraLink and hold CuraLink directly liable for the joint venture’s obligations. Similarly, GI Nexus could be sued and subsequently pierced. If that happens and CuraLink has control over GI Nexus, it could be financially responsible for those damages.

¹² 42 U.S.C. § 1320a-7.

5. Credit Monitoring Responsibility

Caduceus requires any entity that experiences a patient data breach involving over 100 records to offer complimentary credit monitoring services to affected individuals for at least one year. CuraLink may bear responsibility for the costs of this service and for its management.

6. Reputational Harm

A non-traditional “liability” CuraLink could face is reputational harm stemming from an affiliation with GI Nexus. GI Nexus’s recent data breach has damaged its public reputation, so affiliating with it could do the same to CuraLink. Existing and potential customers may avoid doing business with CuraLink due to concerns that similar violations may happen under its management. For many customers, mere association with an organization that has had prior security issues can be enough to make them take their business elsewhere.

III. Analysis of Strategic Options¹³

A. Equity Acquisition

Curalink could acquire an equity interest directly in the GI Nexus entity.

1. Regulatory

An equity acquisition presents high risk of federal and state regulatory violations given GI Nexus’s physician-owned clinical structure and referral pipeline internally and with Saint Rafael Regional Medical Center (“St. Raphael”), which owns 30% of the entity.

CPOM. Although Loyola law is somewhat flexible and permits minority or “friendly physician” models of ownership so long as physicians retain clinical control, Caduceus is far stricter and generally limits ownership and control of clinical assets to physicians or physician-

¹³ Please note Health Privacy, Scope-of-Practice, and Antitrust concerns are likely to persist regardless of the transaction structure and will not be addressed granularly below.

owned entities, making a non-physician equity stake in a clinical practice highly vulnerable to CPOM violations. Additionally, Caduceus requires advance reporting of any direct or indirect ownership change to the Department of Health, which invites higher regulatory scrutiny.

Fraud and Abuse. At the federal level, equity creates a direct financial relationship that implicates the Stark Law if GI Nexus's physician-owners continue referring patients for DHS. It raises AKS concerns because dividends, governance rights, and profit distributions may be viewed as remuneration tied to referral streams. Any resulting claims could escalate into False Claims Act exposure.

Miscellaneous. HIPAA and Caduceus data privacy concerns arise if the breached patient information falls within the scope of the regulations. Reporting requirements and complementary credit monitoring services may be required under Caduceus's statutory framework. Additionally, the federal antitrust statutes may be implicated if the equity acquisition were to substantially consolidate market share or reduce competition in specialty services that GI Nexus and CuraLink offer.

Without any information indicating that CuraLink is owned by licensed physicians, the safest regulatory course is to avoid this deal structure.¹⁴

2. Legacy Liabilities

If CuraLink chooses an equity acquisition, it could be financially responsible for addressing GI Nexus's previous violations. Additionally, CuraLink could incur costs associated with providing the required credit monitoring. This creates a substantial financial and regulatory liability for CuraLink. Moreover, CuraLink would inherit any other unknown violations or liabilities from GI Nexus. If GI Nexus is excluded from federal programs as a penalty for its

¹⁴Based on the information provided regarding CuraLink's business history as an MSO LLC with no prior asset purchases, it is safest to assume that CuraLink is not entirely owned by licensed physicians.

violations, CuraLink could also face exclusion. As with any affiliation option with GI Nexus, CuraLink's reputation may also be harmed with an equity acquisition.

To mitigate these potential liabilities, CuraLink would have to require a substantial escrow to ensure financial recourse if liabilities appear post-closing. At closing, a percentage of the purchase price would be placed into an escrow account. If CuraLink later discovers undisclosed liabilities or is required to pay regulatory penalties, it can recover its losses by making a claim for indemnity.

In addition to the escrow, CuraLink could require GI Nexus to include representations and warranties ("R&W") concerning compliance with HIPAA and Caduceus scope-of-practice requirements. GI Nexus may be required to make a disclosure of violations. Given prior violations, CuraLink could request an extension of the R&W survival period. Instead of a 24-month market survival period, the purchase agreement could extend it to 36 months. This would provide further reassurance to CuraLink and give broader coverage for any unknown violations. It may also be advantageous for CuraLink to require R&W insurance. That way, if GI Nexus breaches the R&W provisions in the purchase agreement, CuraLink could be reimbursed for the violation under the insurance policy.

CuraLink should also require GI Nexus to indemnify against post-closing liabilities. Indemnification would require GI Nexus to reimburse CuraLink for potential losses arising from pre-closing regulatory violations, future litigation stemming from those violations, and any undisclosed liabilities. This would limit CuraLink's responsibility for those liabilities and put the responsibility on GI Nexus. Similarly, CuraLink could require a covenant requiring GI Nexus to complete remediation of the data breach and the scope-of-practice violation.

3. Advantages and Limitations

An equity acquisition in which CuraLink would acquire an ownership stake in GI Nexus, PLLC, offers the highest potential economic upside if GI Nexus successfully rebounds. It also strongly aligns incentives by giving all parties “skin in the game.”

Despite the financial appeal, this option is fraught with legal and governance risks. An equity stake could be interpreted as conveying effective control over clinical operations, creating significant CPOM risk in Caduceus. Governance would be exceedingly complex; St. Raphael already holds a 30% stake, two of five board seats, and dual affirmative veto rights. Any change in equity would trigger heavy negotiations and a high likelihood that St. Raphael would block the transaction or require significant concessions, thereby reducing its attractiveness. Legally, the Stark Law’s “stand in the shoes” analysis becomes highly complex, as physician owners with equity in an MSO-affiliated entity who refer to that practice’s DHS create a layered self-referral exposure that is difficult to mitigate.

From a liability standpoint, CuraLink would effectively assume successor liability for GI Nexus’s pending data breach and scope-of-practice matters, to the extent it, as an equity holder, would be responsible for funding their resolution. Operationally, acquiring equity does not automatically fix underlying problems unless paired with strong management rights, which, in turn, would worsen the CPOM optics. For these reasons, we recommend avoiding a “buy first, fix later” equity strategy.

B. Clinical Asset Purchase

Under this structure, CuraLink would purchase GI Nexus’s clinical assets, such as its valuable imaging and radiation equipment.¹⁵

¹⁵ We would recommend requiring pre-closing inspection of clinical equipment due to its advanced technological nature and the risks associated with using such equipment in the delivery of care.

1. Regulatory

CPOM. Under both Loyola and Caduceus law, CuraLink is prohibited from purchasing clinical assets. CuraLink cannot purchase any of GI Nexus’s diagnostic imaging, radiation, or X-ray technology without risking penalties for CPOM violation. Additionally, these purchases must be reported to the Caduceus Department of Health, and will be highly scrutinized

Fraud and Abuse. Additionally, purchasing clinical assets that generate reimbursable services creates a direct financial incentive tied to utilization and downstream referrals, which will may be seen as an AKS violation. Regulators may examine whether the purchase price reflects anticipated referral volume or goodwill tied to physician referrals. Post-closing compensation or operational integration could be viewed as remuneration to capture referral streams. The financial benefit of purchasing GI Nexus’s assets is tied to CuraLink’s ability to lease the assets back to GI Nexus. However, leasing agreements can produce further AKS violations if the payments are not grounded in Fair Market Value (“FMV”) and commercial reasonableness.

Direct ownership of clinical or DHS-producing assets establishes a clear financial relationship between the entity and referring physicians. Any physician referrals to the acquired clinical assets would be prohibited unless a Stark exception is satisfied. Failure to meet a Stark exception creates strict liability exposure, repayment obligations, and False Claims Act risk.

Because clinical asset purchases would be express CPOM violations, there is no mitigation measure that could satisfy Caduceus’s regulatory scheme, unless the clinical assets were owned by licensed physicians or a physician-owned entity.

2. Legacy Liabilities

Under a clinical asset purchase structure, CuraLink could exclude all undesirable legacy liabilities from the transaction. Still, CuraLink may be forced or choose to assume certain liabilities as an incentive to make a potential clinical asset purchase more attractive to GI Nexus.

3. Advantages and Limitations

This approach would provide direct ownership and control over high-value service lines, which aligns with CuraLink's hub strategy of leveraging shared clinical network equipment. Direct control could also accelerate the standardization and integration of these assets into CuraLink's operational model.

However, this option faces prohibitive legal and regulatory obstacles. The CPOM doctrine in Caduceus generally limits clinical asset ownership to physicians or physician-owned entities, with only narrow exceptions for indirect financial interests. Pursuing a direct clinical asset purchase would invite immediate regulatory scrutiny. Furthermore, any change of ownership of regulated clinical assets in Caduceus triggers mandatory pre-closing filings with extensive disclosures and a sixty-day waiting period, introducing significant timeline risk and potential for denial, which is untenable during a crisis. This structure would also heighten scrutiny under the Stark Law and AKS, as it ties CuraLink's ownership and economic interests directly to referral-generating assets used by GI Nexus physicians for self-referrals.

Operationally, this path would create significant disruption. Payor, vendor, and facility agreements often contain anti-assignment clauses that would be triggered by a change of ownership, leading to complex and time-consuming consent negotiations. From a stakeholder perspective, this option is misaligned. For GI Nexus, it would threaten referral stability and impose an immense burden on an already-stressed operation. For St. Raphael, a clinical asset

purchase would likely trigger its “major transaction” veto and could be viewed as a deviation from its core mission. Ultimately, a clinical asset purchase is a high-friction, slow, and disruptive option that is ill-suited to the immediate goals of stabilization and continuity.

C. Joint Venture

CuraLink may consider forming a joint venture (“JV”) entity with GI Nexus, which would hold either or both clinical and non-clinical assets for integration into CuraLink’s established services network.

1. Regulatory

CPOM. Loyola’s CPOM laws expressly permit non-physician entities to participate in JVs with health service entities, provided the non-physician entity maintains only a minority ownership stake and clinical operational control remains with licensed physicians. However, it is not settled under Caduceus law whether non-physician entities can engage in JVs with healthcare service providers.

Fraud and Abuse. JVs are highly scrutinized for AKS violations when physicians refer patients to an entity in which they have an ownership interest, and profit distributions correlate with referral volume. Given GI Nexus’s internal referral flows and St. Raphael’s existing equity, a JV could be viewed as a vehicle to capture referral-driven revenue. Moreover, joint ownership creates a direct financial relationship between referring physicians and the JV entity. If the JV provides DHS, physician referrals to the entity would be prohibited under Stark, absent an exception. Revenue-sharing tied to service line performance may violate Stark’s compensation requirements.

A JV would pose a very high risk under both the AKS and Stark Law due to existing ownership and referral structures. To minimize fraud and abuse risk, the transaction would need

express provisions mandating FMV capital contributions, FMV distributions entirely unrelated to referral volume, independent governance, and records demonstrating commercial reasonableness. Additionally, to determine whether a joint venture is feasible, more due diligence is required to understand GI Nexus's and St. Rafael's referral systems and distribution structures.

2. Legacy Liabilities

One risk of forming a JV with GI Nexus is that CuraLink could be held liable for the JV's liabilities through piercing the corporate veil. CuraLink may also inherit the risk of exclusion from federal programs such as Medicare and Medicaid due to its affiliation with GI Nexus. The JV entity would become an affiliate of GI Nexus, and, in turn, CuraLink would become an affiliate of GI Nexus due to shared control. Thus, if GI Nexus is excluded from these programs, the JV and CuraLink may be excluded as well. This would significantly harm the JV's operations and, consequently, CuraLink's.

The ideal way for CuraLink to mitigate this risk is to maintain separate books and records to avoid suspicion of commingling. Ensuring the JV is adequately capitalized and separate from GI Nexus will prevent it from being held responsible for GI Nexus's liabilities. If CuraLink is excluded, it could file a request with the OIG to be removed from the exclusion list. This process is complicated and time-consuming, and must be avoided. CuraLink must review GI Nexus's referral patterns and past claims as part of its due diligence.

3. Advantages and Limitations

A JV involving CuraLink, GI Nexus, and potentially St. Raphael could be formed to share economics and governance over specific business lines. A JV offers a flexible structure that can be designed to keep clinical control with physicians while granting CuraLink strong

non-clinical governance rights. It allows for pre-agreed performance milestones, aligns growth incentives, and could strategically include St. Raphael as an ally.

However, a JV also introduces significant risk of governance deadlock, especially with three parties involved and St. Raphael's existing veto posture. The documentation and negotiation process for a JV is complex and can significantly slow down a transaction, making it a poor choice for the immediate stabilization needed here. Depending on its structure, a JV could still trigger Caduceus's change-of-ownership filing requirements and CPOM concerns. While a JV could be a viable chassis for a later phase of the relationship, it is not the fast-acting tool required for Phase One. The Tri-Party Covenant proposed in Section IV, achieves many of the alignment benefits of a JV without the structural overhead and delay.

D. Non-Clinical Asset Purchase (Outright)

CuraLink could pursue an outright purchase of GI Nexus's non-clinical infrastructure, including its IT systems, intellectual property, administrative offices, and related staff and processes.¹⁶

1. Regulatory

CPOM. Neither Loyola nor Caduceus prohibits the purchase of non-clinical assets. CPOM risks would arise; however, if CuraLink exercised "de facto" control over GI Nexus's clinical operations by purchasing its non-clinical assets. Thus, it is important that the transaction between the parties expressly list specific non-clinical assets that CuraLink would purchase at a commercially reasonable value. It is also important to specify that any purchase of clinical assets would not affect the exclusive clinical authority held by GI Nexus's physicians.

¹⁶ CuraLink could also purchase all furniture, fixtures, and nonclinical equipment owned by GI Nexus.

Fraud and Abuse. Acquisition of non-clinical assets generally does not directly induce or influence referrals and is unlikely to violate AKS. Risks arise only when assets are transferred above or below FMV, which could be viewed as disguised remuneration. Indirect influence over operational systems that increase usage could still create AKS scrutiny.

There is minimal Stark exposure with a non-clinical asset purchase because CuraLink would not own DHS entities or clinical revenue streams. An improper financial relationship would only exist if compensation arrangements were tied to revenue generated by DHS services.

2. Legacy Liabilities

Due to GI Nexus's recent regulatory issues, purchasing its assets will associate CuraLink and GI Nexus, which could lead to reputational harm. Existing and potential customers may avoid doing business with CuraLink due to concerns of recurring violations. Additionally, affiliation with GI Nexus may result to CuraLink's exclusion from federal programs.

While CuraLink cannot entirely eliminate these risks, it can mitigate them through due diligence and the establishment of a compliance program. CuraLink must perform due diligence to identify potential vulnerabilities prior to closing and structure the transaction to avoid successor liability. Furthermore, CuraLink should require indemnification or remediation prior to closing.

Additionally, instituting a post-closing compliance program would not only help prevent recurring regulatory issues but also signal to customers that CuraLink is taking steps to secure the purchased assets. An effective compliance program would designate compliance officers, establish procedures for correcting potential violations, and monitor system activity.

CuraLink should also retain a public relations firm to help mitigate any reputational harm arising from its affiliation with GI Nexus. This marketing program would demonstrate

CuraLink’s renewed commitment to compliance and remediation of regulatory concerns, especially those related to patient data security.

3. Advantages and Limitations

An outright purchase of non-clinical assets is more closely aligned with Caduceus’ CPOM rules, as CuraLink’s model already involves owning and leasing back non-clinical assets while physicians retain clinical control. Operationally, it provides a direct lever to address the root causes of the recent data breach by overhauling IT access controls, vendor controls, and EMR security. Financially, this path supports CuraLink’s scaling thesis by enabling the rapid integration of GI Nexus’s administrative functions into CuraLink’s established centralized platforms.

The primary disadvantages relate to timing and perception. Executing an immediate purchase would create a substantial transition burden, requiring the inventorying and migration of systems amidst a crisis. Financially, it forces a valuation of GI Nexus’s non-clinical systems now, when they are in disarray and difficult to price fairly. If executed clumsily, St. Raphael could perceive this as a “control shift,” potentially triggering its veto powers. While this option strongly aligns with CuraLink’s long-term goals and is workable for GI Nexus and St. Raphael if managed carefully, it is a better endpoint than a starting point. Our recommended structure achieves the same outcome through a phased earn-in, which avoids the risks of premature valuation and operational disruption.

E. MSO Service Affiliation

The final option, and our recommended chassis, is an MSO service affiliation. CuraLink would become GI Nexus’s exclusive Management Services Organization, assuming responsibility for all non-clinical operations under a Management Services Agreement (MSA).

1. Regulatory

CPOM. Under the proposed MSA, CuraLink faces virtually no risk of violating CPOM. In accordance with CuraLink’s traditional business practices, the MSA structure will allow CuraLink to coordinate centralized non-clinical organizational tasks, such as IT, EMR, telehealth, supplier contracting, payor negotiations, and daily office and human resources support. The GI Nexus physicians will retain exclusive control over clinical decisions and their clinical assets. By expressly stating in the MSA that CuraLink will not influence the physicians’ management, budgeting, staffing, or operational authorities, regulators in both Loyola and Caduceus are very unlikely to find CuraLink asserting “de facto control” over GI Nexus, and will likely find no CPOM risk.

Fraud and Abuse. Management fees paid by GI Nexus to CuraLink may constitute “remunerations” under AKS. If fees are solely tied to revenue, profitability, or service utilization, regulators may determine that CuraLink is indirectly benefiting from referral volume. Furthermore, the centralized services that CuraLink would provide to GI Nexus (EMR, payor contracting, and operational support) create a financial relationship that regulators might analyze to see if they induce referrals. Because St. Rafael has 30% equity in GI Nexus, and refers patients to GI Nexus, regulators may also scrutinize the relationship between the entities as one based on renumeration tied to referral flow.

The MSA creates an indirect compensation arrangement between the GI Nexus physicians and CuraLink that may implicate the Stark Law. If GI Nexus physicians refer patients for DHS, such as medical imaging, and CuraLink’s compensation is tied to those revenues, this may create a prohibited financial relationship. For instance, if the compensation for CuraLink’s service fees is based on a percentage of revenue, and the percentage is reduced as total revenue

for DHS services reaches certain benchmarks, regulators are more likely to find a Stark Law violation. However, there is a statutory exception to the Stark Law when a compensation agreement is in writing and based on fair market value.¹⁷

To avoid AKS and Stark violations, the MSA must be grounded in FMV and commercial reasonableness. While CuraLink's service fee can be a flat fee, cost-plus, or a percentage of revenue, both the purchase price for the non-clinical assets and any payment by GI Nexus for leasing the assets must be separate and unrelated to referral volume. If both sides of the transaction are based exclusively on FMV and are commercially reasonable, it will be difficult for regulators to find any AKS or Stark violation.

2. Legacy Liabilities

CuraLink's primary liability would be reputational harm. As mentioned earlier, GI Nexus's prior violations create a greater risk of association with them. CuraLink's reputation may be harmed by contracting to serve as GI Nexus's MSO, as clients may associate CuraLink with GI Nexus's previous regulatory concerns.

CuraLink can mitigate this potential liability by clearly defining its role and involvement with GI Nexus. When entering the MSO, CuraLink can state in plain language that it has only management responsibilities for non-clinical operations and that it does not own any part of GI Nexus. This will give clients and the media a clear view of CuraLink's and GI Nexus's affiliation and demonstrate that CuraLink has no responsibility or connection to the prior violations.

¹⁷ 42 CFR § 411.357(l).

3. Advantages and Limitations

Pursuing an MSA is the fastest route to gaining control over and remediating the critical operational deficiencies in IT, EMR governance, HR, vendor management, and the revenue cycle.

Legally, the MSA structure is fully aligned with Caduceus's CPOM constraints, as CuraLink would control only non-clinical functions while licensed physicians retain sole authority over clinical matters. This clear separation avoids triggering change-of-ownership filings for clinical assets. From a business perspective, the MSA requires minimal upfront capital, is scalable for future expansion in Caduceus, and aligns with CuraLink's proven and successful business model. A service relationship, rather than ownership, also limits CuraLink's successor liability exposure for GI Nexus's pre-existing issues.

The primary downside is that a standard MSA alone may not provide sufficient economic upside to justify the significant investment required for remediation. Furthermore, the MSO must be structured carefully to avoid the appearance of "shadow control" over clinical decisions, which could attract regulatory scrutiny. We believe these concerns are best addressed by pairing the MSA with a structured earn-in to capture long-term upside and a formal clinical independence protocol to memorialize the division of responsibilities.

IV. Recommended Structure: "Turnaround + Earn-In" with a Tri-Party Covenant

Based on our analysis, we recommend that CuraLink pursue a two-phase transaction. This structure is designed to stabilize GI Nexus, mitigate risk for CuraLink, align all stakeholders, and create a path to long-term value creation.

A. Phase One: Turnaround

The first phase consists of an immediate MSO service affiliation, combined with a Turnaround Services Agreement that would provide for a much broader scope and greater authority for CuraLink than is typically seen in Transition Services Agreements used in these arrangements. CuraLink would assume immediate control over all non-clinical operations with explicitly defined reserved powers. Key actions would include:

- **IT and Security Control:** Gaining immediate administrative control over access policies, vendor remote access, and incident response workflows. CuraLink would have the authority to enforce Business Associate Agreements (BAAs) and revoke access for non-compliance.
- **Operational Control:** Taking over non-clinical hiring, billing systems, coding audits, and accounts receivable cleanup. CuraLink would also renegotiate supplier and payor contracts.
- **Compliance Remediation:** Implementing a milestone-driven work plan to address the two major crises.
 - **Data Breach Response:** Notifying patients and the Caduceus Health Department within the ten-business-day statutory deadline, initiating mitigation steps, performing a full forensic investigation, and conducting a BAA audit of all vendors.
 - **Scope of Practice Remediation:** Immediately reviewing supervision protocols, implementing a revised delegation matrix to clarify roles, and deploying mandatory training. CuraLink will also prepare a response package for the Board of Nursing in coordination with counsel.

The economics for Phase One would be structured as an FMV base fee for services, comprising a fixed fee and an objective, non-referral-based adder (e.g., per site, per provider).¹⁸ Short-term incentives will be tied to non-clinical Key Performance Indicators (“KPIs”), such as reducing accounts receivable (“AR”) days. This ensures the fee structure is commercially reasonable and does not depend on the volume or value of referrals, in compliance with the Stark Law.

B. Phase Two: Earn-In

Phase Two is designed to unlock CuraLink’s upside potential, earned through successful performance in Phase One. It includes two components:

1. **Stepped-Up Economics:** Upon achieving pre-defined milestones, such as satisfying breach response obligations, resolving the Board of Nursing inquiry, and sustaining KPI improvements, CuraLink’s compensation under the MSA would increase according to a pre-agreed formula.¹⁹
2. **Option to Purchase Non-Clinical Assets:** The cornerstone of the Earn-In is an option for CuraLink to purchase a pre-defined pool of GI Nexus’s non-clinical assets at a future date. This option can only be exercised after all compliance and operational milestones are met and St. Raphael’s key concerns (e.g., charity care reporting) are addressed. The pricing will be based on an independent FMV appraisal at the time of exercise, avoiding revenue-based formulas that could create Stark Law risks. After exercising the option, the MSA would evolve, allowing CuraLink to either lease the assets back to GI Nexus or fully integrate them into its centralized platform.

¹⁸ The FMV base fee for services should be determined by an independent third-party valuation company.

¹⁹ To avoid the appearance of paying for referrals and to maintain consistency in FMV valuation, this earn-in formula must not be based upon increased financial results of GI Nexus.

C. Tri-Party Mission and Compliance Covenant

To secure the transaction and convert St. Raphael from a potential obstacle into a supportive partner, we recommend executing a tri-party covenant between CuraLink, GI Nexus, and St. Raphael. This binding agreement would formalize commitments to mission and charity care protections, establish transparent reporting standards that directly address St. Raphael's past inquiries, create a joint steering committee for non-clinical governance, and pre-negotiate the definition of "major transaction" to engineer a clear consent pathway for Phase Two. Moreover, careful drafting will ensure that any antitrust concerns are adequately addressed in advance. This covenant is the key to transforming an adversarial dynamic into a collaborative one.

V. Due Diligence

Importantly, there still may be key information and missing facts that could ultimately alter our analysis and recommendation. Below is a stratification of diligence requests, with the corresponding objective for each.

A. High Priority

Regulatory Incidents. CuraLink needs a consolidated "regulatory incidents" packet (breach report, forensics, notifications, regulator responses, cyber coverage, Board of Nursing correspondence, inspection findings, and staffing-policy documents) to size HIPAA and scope-of-practice exposure and confirm that a short-term Turnaround MSA can fix issues without triggering successor liability or licensure crises.

Referral Patterns and Financial Dependence. CuraLink should obtain granular referral and revenue data by source and service line, along with payer mix, margins, AR aging, and charity-care/bad-debt metrics, to assess Stark and AKS sensitivity, test turnaround viability, and

support a defensible FMV and commercial reasonableness model that does not rely on referral value.

Ownership and Governance. CuraLink needs a full ownership and governance picture (entity chart, cap table, GI Nexus governing documents, and St. Raphael equity/affiliation agreements) to pinpoint consent rights, preserve charity-care and mission obligations, and design Phase One and Phase Two structures that respect CPOM while avoiding indirect clinical control

Material Contracts Review. CuraLink must review key hospital, payor, and critical vendor contracts, focusing on assignment, change-of-control, “management change” triggers, and termination rights, to ensure a remediation-focused MSO does not default existing agreements and that any future expansion can occur without sacrificing core revenue or infrastructure.

Threatened and Pending Litigation. CuraLink needs a complete map of pending and threatened litigation, demands, audits, and investigations, with status and exposure estimates, to categorize legacy liabilities and structure targeted indemnities, escrows, and walk-away rights across both the interim MSA and any longer-term affiliation.

Financials. CuraLink should obtain multi-year, service-line-level financials, cash-flow and capex detail, and any reporting provided to St. Raphael, to validate GI Nexus’s underlying performance, calibrate MSO fees and non-clinical pricing, and support the economic assumptions baked into its turnaround and earn-in thesis.

Independent Appraisal. CuraLink requires independent FMV analyses and internal benchmarking for MSO fees and any non-clinical asset transfers or leases, so that both near-term remediation economics and future earn-in structures are objectively supportable and defensible under Stark and AKS.

Federal Program Exclusion. CuraLink needs OIG and state exclusion screening results for GI Nexus, its owners, and key personnel, plus evidence of routine screening practices, to ensure no excluded parties will taint federal program claims flowing across the CuraLink platform.

B. Low Priority

As a lower-priority context, CuraLink should request concise packets on general compliance infrastructure, IT/cyber posture beyond the breach, HR and staffing, market/quality metrics, PR exposure, and legacy insurance, using these to refine integration and messaging rather than to drive the core go/no-go decision on the Step 1 remediation MSA.

VI. Conclusion

We unequivocally recommend that the Board of Directors approve pursuing a transaction with GI Nexus structured as a **two-phase MSO affiliation featuring a “Turnaround + Earn-In + Tri-Party Covenant.”**

This phased approach allows CuraLink to leverage its core competency as a premier MSO to generate immediate service revenue while executing a rapid turnaround of GI Nexus’s operations. It insulates CuraLink from successor liability and avoids the regulatory pitfalls of a premature acquisition in Caduceus. The earn-in structure creates powerful, asymmetric upside, allowing CuraLink to purchase stabilized, de-risked assets at a fair price only after creating the value itself. By proactively engaging St. Raphael through the tri-party covenant, this structure aligns all key stakeholders and provides a clear, executable path forward. This strategy not only solves GI Nexus’s immediate crises but also establishes a scalable template for CuraLink’s successful expansion into the state of Caduceus.