On November 17, 2015, Greater Waterbury Health Network, Inc. ("GWHN") and Prospect Medical Holdings, Inc. ("PMH" and, together with GWHN, the "Applicants"), received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA")requesting additional clarification for certain deficiencies identified in the Application submitted on October 28, 2015. The Applicants' Response to these deficiencies is provided below.

OHCA Questions

1. Please comment on the November 5, 2015 report by Dow Jones & Company that Leonard Green & Partners plans to sell PMH and in your answer provide the following:

a) a description of Leonard Green & Partners and its present ownership stake and control of PMH; and

Response:

Neither PMH nor any of its subsidiaries are affiliated with the Deal Pipeline's website or the LBO Wire. Therefore, PMH cannot explain how or why those particular reports were generated.

PMH can confirm, however, that PMH has retained Morgan Stanley to review and assess additional sources of investment to support its overall growth strategy, and that PMH has been in discussions with additional investment groups to evaluate opportunities to partner during this next phase of the company's growth.

PMH is a growing company that is performing very well and receives inquiries from interested investors. The company is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth.

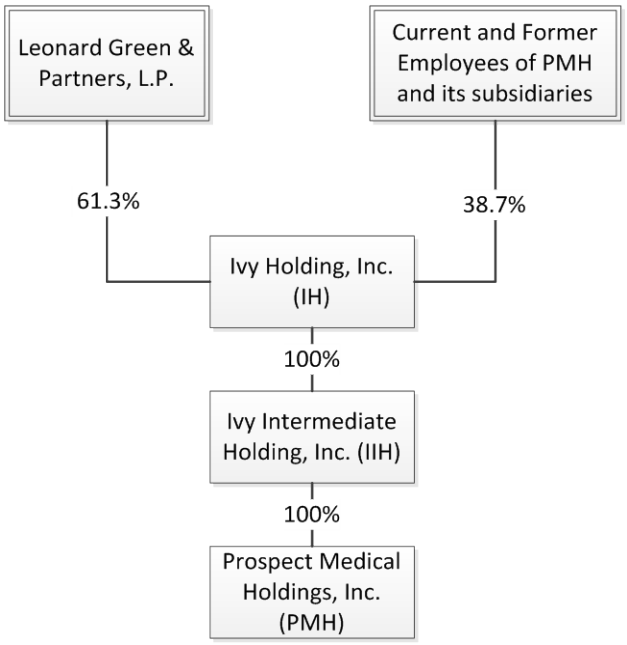
About Leonard Green & Partners, L.P. ("Leonard Green") - Source: www.leonardgreen.com

"Leonard Green is one of the nation's preeminent private equity firms with over $15 billion of private equity capital raised since its inception. Founded in 1989, the firm has invested in 76 companies in the form of traditional buyouts, going-private transactions, recapitalizations, growth capital investments, corporate carve-outs and selective public equity and debt positions. Based in Los Angeles, CA, Leonard Green invests in established companies that are leaders in their markets." [1]

The affiliated investment funds of Leonard Green own approximately 61.3% of the common stock of Ivy Holding, Inc. ("IH"), a Delaware corporation which owns 100% of the stock in Ivy Intermediate Holding, Inc. ("IIH"). IIH is a Delaware corporation which owns 100% of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets, liabilities or operations. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

[1] http://www.leonardgreen.com/news/081415-Ellucian-n.pdf

Figure 1 – Relationship of Leonard Green to PMH



Other healthcare related investments held by Leonard Green include CHG Healthcare Services, RestorixHealth and US Renal Care.

The engagement with Morgan Stanley to review and assess additional sources of investment for PMH will likely conclude within the next year. PMH will only proceed further with any additional investors if we find a partner that supports our current growth strategy. The engagement with Morgan Stanley may not yield any additional investment into PMH. This is an evaluation at this point in time.

b) the timing of any proposed sale of PMH and its impact on the proposed Transaction.

Response:

PMH's pursuit of additional investment partners will not affect the planned acquisition of GWHN. Capital funding associated with PMH's acquisition of GWHN is currently available. The rationale for pursuing additional investment partners at this time is to prepare the organization for future growth and to support PMH's overall growth strategy.

PMH's pursuit of additional investment partners will not affect the future operations of GWHN other than to support the overall growth of PMH – which could also benefit GWHN as part of a growing system. PMH's short and long term strategy and focus on transforming the healthcare delivery model will not change. PMH will continue to focus on its current operations and will continue to invest in its hospitals, medical groups, CRC network and related business. The management of PMH will remain unchanged.

2. At page 21 of the Application, the Applicants state that PMH will spend or commit to spend the Capital Amount (defined in the Asset Purchase Agreement ("APA") as $51.5 million) on capital projects in the seven years following the Closing Date (the "Capital Commitment"). According to the Application at page 27, in October 2012, PMH was prepared to spend at least $70 million over a five-year period as part of its proposed asset purchase of GWHN. With respect to this aspect of the Transaction, please describe the factors that led PMH to make a smaller capital commitment over a longer period of time in 2015 and for GWHN to accept these terms.

Response:

The facts and circumstances, the operational results and the value of GWHN were very different in 2012 as opposed to 2015. In fact, the operational results and the value of GWHN have deteriorated significantly from the time that the parties entered into a letter of intent in early 2015 as volume and revenue declines, combined with increased expenses, have contributed to significant losses during the past six months.

Furthermore, it should be noted that PMH had offered $25 million as the purchase price in 2012 as opposed to $38.3 million ($31.8 million plus $6.5 million of assumption of capital lease debt obligation) as proposed in this transaction.

Finally, when PMH and GWHN renewed their negotiations in early 2015, the board of GWHN requested that PMH agree to the economic terms and conditions that it had previously negotiated in the APA with Vanguard / Tenet, which had already been approved by (i) the board of directors of GWHN; (ii) OHCA; and (iii) the Attorney General of Connecticut.

It should be noted that PMH views the Commitment Amount as the minimum that it would spend for capital expenditures at GWHN. If there is a need to spend more on such projects that will contribute to GWHN's growth, PMH will consider all such capital expenditures.

3. In Section 6.10 of the APA (page 189 of the Application), the parties agree that PMH will be relieved of its Capital Commitment if, among other things, a Legal Requirement (as defined in the APA) is enacted or imposed that "adversely or disproportionately affects" for-profit hospitals. In the Application at page 21, the parties state that PMH will be relieved of the Capital Commitment if any Legal Requirement would "adversely affect a disproportionate number" of for-profit hospitals. With regard to this provision of the APA, please respond to the following questions:

a) Please explain why the Capital Commitment made in this Transaction could be potentially eliminated in the event of the enactment or imposition of certain Legal Requirements, rather than deferred, as in PMH's conversion application to purchase the assets of Eastern Connecticut Health Network (the "ECHN Transaction").

Response:

First, it should be noted that GWHN negotiated a deal separate and apart from ECHN. Each deal stands on its own. Neither GWHN nor ECHN were privy to the other's negotiations. The GWHN board negotiated a deal (taking the transaction as a whole) that it believed was in the best interests of GWHN and its surrounding communities. Furthermore, PMH views the Commitment Amount as the minimum

that it would spend for capital expenditures at GWHN. If there is a need to spend more on such projects that will contribute to GWHN's growth, PMH will consider all such additional capital investments. .

Second, please note that a Legal Requirement that discriminates against or adversely or disproportionately affects for-profit hospitals would require PMH to consult with the Local Board to determine an alternate mutually agreeable capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirements.

b) Explain the intended meaning of "adversely affects" and provide examples of circumstances that this term might describe. Also, please comment on whether it is the parties' intent that PMH be relieved of its Capital Commitment if a disproportionate number of for-profit hospitals are affected by a Legal Requirement that is not imposed by the State of Connecticut or an agency thereof.

Response:

It is impossible to describe the universe, or set of circumstances that may arise from Legal Requirements that may negatively or adversely affect the operational performance of a hospital. However, and without limiting the generality of the universe of Legal Requirements that may negatively or adversely affect the operations of a hospital, an example would be the passage of a Legal Requirement by any federal or state regulatory authority after the Closing, pursuant to which a for-profit hospital would receive less reimbursement for the same service than a not-for profit hospital. In such circumstances GWHN's operations will be adversely affected. Other examples may include conditions placed on the operations of GWHN post-closing that do not currently exist on the operations of the hospital and/or that other not-for-profit hospitals in the state of the Connecticut would not be required to follow, but only if such conditions negatively or adversely affect the ongoing operations of GWHN. We anticipate the probability of such an event to be extremely low, and in fact are not aware that any such circumstance has ever occurred.

4. Page 21 of the Application provides that the Capital Commitment may be spent on "the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community." In connection with this statement, please respond to the following questions:

a) Do the parties intend that PMH may spend all or part of the Capital Commitment to acquire other Waterbury-area healthcare businesses rather than on the capital needs of the Hospital Businesses or for Physician Recruitment Expenditures (as both terms are defined in the APA)?

Response:

The parties have not yet prepared a capital investment plan. GWHN and PMH have agreed to seek the input of the Local Boards and medical staff to produce a capital plan post-closing that will ultimately determine the capital projects and priorities.

b) Please describe which types of healthcare businesses other than the Hospital Businesses that would be subject to acquisition.

Response:

In order to better position GWHN as a premier choice for healthcare in its community, PMH believes that it will need to continually evaluate the facilities and markets for future capital projects. Immediately post-closing, as a part of the strategic planning process, PMH would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which GWHN operates. This strategic planning process would be led by the local management team; however the resources of PMH would provide the necessary capital and expertise to enhance existing services and add new service lines. It is expected that the types of healthcare businesses other than the Hospital Business, if any, that could be considered would include outpatient facilities, such as imaging or ambulatory surgery centers, behavioral health, home health agencies, urgent care clinics and other ambulatory care businesses. Should the opportunity arise, PMH would also consider acquiring other inpatient acute or behavioral health facilities in Waterbury's service areas and the surrounding communities.

Working with the local leadership, PMH will identify and prioritize the identified capital projects. PMH's objective is to implement growth initiatives for the benefit of the surrounding communities served by GWHN so long as that care can be delivered in a high quality and financially responsible manner.

5. In reference to the priority capital projects identified by Applicants on page 72 of the Application, address the following:

a) Provide the years beyond useful life for the facilities and equipment listed, as applicable;

Response:

Project	Cost	Years beyond useful life
Expansion of ED/Development of urgent care	$3.75M	
Upgrade OB/Women's health	$2M	16 Years
Upgrade outpatient surgery	$2M	
Equipment		
Replace interventional radiology equipment	$1.7M	7 years
Upgrade surgical/anesthesia equipment	$1.5M	5-20 years

b) Elaborate on the main campus upgrades involving the ED/development of urgent care, OB\Women's health and outpatient surgery; and

Response:

The Emergency Department at Waterbury Hospital was built to accommodate 35,000 patients annually while the actual utilization is about 50,000, resulting in issues of throughput which delays "door to doctor" time. Lengthy waits result in higher than average "Left Without Being Seen" (LWOS) rates. The LWOS rate has exceeded 4% while national averages are 2.5 to 3%. Hallways are consistently used as

patient rooms. Expansion of the emergency department will improve access to care, decrease LWOS, and improve patient throughput, while improving patient privacy. In sum, it will improve patient access and quality of care. Waterbury Hospital presently does not provide urgent care which is sorely needed for both our existing patients as well as to more conveniently and efficiently serve existing patients, many of whom use the more expensive emergency department.

OB/Women's Health area has not been upgraded since the 1980s and is badly in need of cosmetic repairs and amenities.

There is not a separate area for outpatient surgery which has become standard for healthcare organizations. Particularly due to the change in reimbursement, patients are being redirected to outpatient surgery centers, which Waterbury Hospital does not have, and which is a disadvantage to the hospital, but more importantly, restricts access to GWHN patients.

c) Elaborate on the scale and services associated with the multi-use Outpatient Centers contemplated for Southbury, Naugatuck and Waterbury.

Response:

Presently Waterbury Hospital provides several healthcare services in Naugatuck, Southbury and Watertown. However, these services are not conveniently co-located, nor are they organized and offered to patients in a convenient, one-stop shopping environment. It is the goal to locate outpatient services around a nucleus of physicians in an environment with adequate parking and convenient access to patients.

d) Please elaborate on how the Bipartisan Budget Act of 2015 and its restrictions on off-campus hospital departments billing under Medicare's hospital outpatient prospective payment system ("OPPS") might affect the development of the multi-use Outpatient Centers.

Response:

It will not have an impact because the nucleus of the outpatient strategy is physician-based practices, which has not changed. These centers will not operate as hospital services, but as physician practices.

6. On page 980 of the Application, Applicants identified certain capital improvements made recently, including investments in an XI robot and replacing a CT scanner as well as a C-Arm. Please provide a list of all capital projects (excluding routine maintenance of physical plant and equipment) undertaken by GWHN since January 2013, including, but not limited to the projects referenced, and please identify the associated costs of each capital project.

Response:

Capital Project	Department	Cost	Date
Anesthesia Equipment	Operating Room	$82762	02/21/2013
Scope Disinfecting System	Gastroenterology	$54540	06/11/2013
Surgical Laser Holmium	Operating Room	$42000	07/28/2014
Ultrasound Imaging System	Emergency Department	$22000	08/25/2014
Surgical Navigation System	Operating Room	$489992	11/06/2014
Echo Cardiology Imaging System	CVOR	$95,000	04/01/2015
Surgical Robotic System	Operating Room	$1935000	03/16/2015
Telemetry Monitoring System	Telemetry	$379905	03/18/2015
C-Arm	Operating Room	$225721	03/25/2015
CT Scanner	Radiology	$695000	07/01/2015
Infusion Pumps	Nursing	$1121904	09/09/2015

7. As of the date of Applicant's response to this Completeness Letter, please update the following:

a) the current Net Working Capital (as defined in the APA) of GWHN calculated in accordance with the methodology agreed by the parties on Annex A of the APA;

Response:

GWHN FILING TABLES

	Balance Sheet as of 9/30/2015 (Ownership Adjusted)	Pro Forma: Retained by Surviving Entity	Pro Forma: Purchased/ Assumed by Prospect
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 22,050,744	$ 22,050,744	$ -
Short-term Investments	$ 1,496,670	$ 1,496,670	$ -
Net Accounts Receivable	$ 31,929,609	$ 176,254	$ 31,753,355
Accts Receivable - Other	$ 3,944,727	$ 3,412,833	$ 531,894
Inventories	$ 3,449,371	$ -	$ 3,449,371
Prepaid Insurance and Other Expenses	$ 2,035,847	$ 204,631	$ 1,831,216
Due From Affiliates	$ (248,126)	$ (248,126)	$ -
Total Current Assets	$ 64,658,842	$ 27,093,007	$ 37,565,836
Noncurrent Assets Who Use Is Limited:			
CHEFA Bond Issue Cost	$ 236,379	$ 236,379	$ -
Investments	$ 26,598,047	$ 26,598,047	$ -
Board Designated Funds	$ -	$ -	$ -
Loans and Other Receivables	$ 262,796	$ 262,796	$ -
Funds Held in Trust by Others	$ 43,411,397	$ 43,411,397	$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567
Net PP&E	$ 35,691,698	$ 2,056,994	$ 33,634,705
Total Assets	**$ 172,672,727**	**$ 99,658,619**	**$ 73,014,108**
Liabilities			
Current Liabilities			
Accounts Payable and Accrued Expenses	$ (28,992,385.78)	$ (2,828,062)	$ (26,164,323.85)
Current Portion of Accrued Pension Liability	$ (3,867,000)	$ -	$ (3,867,000)
Current Portion of Long Term Debt	$ (2,041,653)	$ (901,423)	$ -
Due to Third-Party Payors	$ (7,759,364)	$ (7,759,364)	$ -
Total Current Liabilities	$ (42,660,402)	$ (11,488,849)	$ (30,031,324)
Long-Term Debt	$ (28,327,258)	$ (24,703,887)	$ (3,623,371)
Other Long-Term Liabilities:			
Workers Compensation	$ (11,601,078)	$ (11,601,078)	$ -
Pension	$ (7,746,917)	$ -	$ (7,746,917)
Malpractice	$ (1,638,066)	$ -	$ (1,638,066)
Asbestos Abatement	$ (2,898,529)	$ -	$ (2,898,529)
Other Long-Term Liabilities	$ (10,819,922)	$ (10,819,922)	$ -
Total Other Liabilities	$ (63,031,770)	$ (47,124,887)	$ (15,906,883)
Total Liabilities	**$ (105,692,172)**	**$ (58,613,736)**	**$ (45,938,207)**
Net Assets	$ 66,980,555	$ 41,044,883	$ 27,075,901
Net Balance Sheet Items	**$ 172,672,727**	**$ 99,658,619**	**$ 73,014,108**

	Cash Accounts	Liquid	Restricted
	$ 22,050,744	$20,286,367	$ 1,764,377
	$ 1,496,670	$ 1,298,106	$ 198,564
	$ 26,598,047	$14,182,633	$ 12,415,414
	$ -	$ -	$ -
	$ 43,411,397	$ -	$ 43,411,397
	$ 93,556,858	$35,767,106	$ 57,789,752

Proceeds Calculation	9/30/2015
Proceeds	
Enterprise Value	$ 31,800,000
Working Capital Adjustment	$ 4,601,512
Total Gross Proceeds	$ 36,401,512
PM Assumed Liabilities	
Asbestos Abatement	$ (2,898,529)
Nurses Pension	$ (27,000,000)
Hospital Cash Balance Plan	$ (11,613,917)
Total Assumed Liabilities	$ (41,512,446)
Net Proceeds	$ (5,110,934)
Unrestricted Cash	$ 35,767,106
Total Unrestricted Cash and Net Proceeds	$ 30,656,172
Cash Needs at Closing	
Estimated Transaction Costs	$ (1,450,000)
Bank Debt	$ (24,094,638)
Debt Swap	$ (1,512,596)
Total Cash Needs at Closing	$ (27,057,234)
Net Cash Post Closing Liabilities & Expenses	$ 3,598,937

b) a description of the methodology to be used in Annex A;

Response:

The methodology has not yet been prepared, but will be consistent with the results shown in a) above.

c) the current amount of capital lease obligations of GWHN;

Response:

Waterbury Hospital							
Capital Leases							
Footnote #7							
	Lease Name	**2016**	**2017**	**2018**	**2019**	**Thereafter**	**Total**
Waterbury Hospital	Allegheny	129,392	123,520			-	252,912
	Trinity	161,789	-			-	161,789
	Johnson & Johnson	9,491					9,491
	Mazuma	461,088	452,492	465,631.48			1,379,212
	Baxter	201,915	188,212	211,810.49	237,353.52	226,628	1,065,919
	Toshiba	96,001	97,754	100,978.54	104,309.68	107,751	506,794
	Intuitive	381,226	390,880	400,778	410,926	104,347	1,688,157
		-	-			-	-
	Total Waterbury Hospital	1,440,902	1,252,858	1,179,198	752,589	438,726	5,064,272.64
AMG	**Lease Name**	2016	2017	2018	2019	Thereafter	Total
	Everbank Commercial Finance	13,931	14,612	6,298		-	34,840
	Wells Fargo - Copiers	1,061	1,096	1,132	1,170	298	4,757
	Total AMG	14,992	15,708	7,430	1,170	298	39,598
	Total Capital Leases per Schedule	1,455,893	1,268,566	1,186,628	753,759	439,024	**5,103,870**
	Total per Financial Statements					-	**5,103,871**
	Difference	1,455,893	1,268,566	1,186,628	753,759	439,024	(1)

d) the current Asbestos Abatement Liability (as defined in the APA) of GWHN;

Response:

$2,898,529

e) the current amount of Unfunded Pension Liabilities (as defined in the APA) of GWHN;

Response:

CHCA Pension = $27,000,00

Cash Balance Plan = $11,613,917

f) the current amount due for GWHN to satisfy the bond obligations as required by Section 5.15 of the APA (page 182 of the Application); and

Response:

Approximately $23,700,000 (CHEFA) bonds

$1,700,000 (swap obligations)

g) based on the responses to the subsections (a) through (f) above, please provide an updated estimated purchase price for GWHN's assets after adding Net Working Capital and subtracting the capital lease obligations, Unfunded Pension Liabilities, Asbestos Abatement Liability, and the amount due for GWHN to satisfy its bond obligations.

Response:

SEE ATTACHED AS EXHIBIT Q7G-1

8. In response to Question 32 of the Application, at page 71, the parties state that if any of GWHN's joint venture interests cannot be transferred at Closing, the purchase price will be reduced to reflect the value allocable to the joint venture interest not transferred. With respect to this statement, please provide the following:

a) What is the current status of the efforts to have PMH acquire GWHN's ownership in the two joint ventures with St. Mary's Hospital, the Harold Leever Regional Cancer Center, Inc. and the Heart Center of Greater Waterbury, Inc.?

Response:

Saint Mary's has consented to GWHN's transaction and the transfer of its interest in Harold Leever Regional Cancer Center, Inc. as part of the transaction. The Heart Center of Greater Waterbury, Inc. is a corporate entity that was formed to facilitate the development of a heart program in Waterbury. The assets of the program belong to the individual hospitals Saint Mary's and GWHN plan to submit a modification of the Certificate of Need to permit the dissolution of the corporate entity. No change in the purchase price will occur with respect to such dissolution.

b) What valuation methodology would be used to determine the value of GWHN's joint venture interests if these interests are not transferred and a reduction in the purchase price needs to be taken.

Response:

The consent of Saint Mary's has been obtained and the parties anticipate the transfer will be part of the closing of the transaction.

c) What is the estimated value of these GWHN joint venture interests when applying the valuation methodology described in subsection (b) above.

Response:

Please see response above.

9. During the 2012 request for proposals ("RFP") process, Tenet/Vanguard and PMH both submitted proposals to purchase GWHN. Tenet proposed a joint venture, whereas PMH proposed an asset purchase. Reference is made to page 26 of the Application where Applicants state that the GWHN Board of Directors, based on the Task Force's recommendation, preferred the Tenet/Vanguard proposal over PMH's as "the joint venture model will better ensure continuing community engagement with the Hospital." With respect to this statement, please elaborate what specific concerns the Board and Task Force had for an asset purchase versus a joint venture, and how those concerns have been allayed by PMH and the proposed governance structure for the post-closing hospital in this transaction.

Response:

In the prior transactions, the Board was able to negotiate a joint venture structure which includes fairly robust local presence in the governance structure. Since the terms of the prior transactions, GWHN has experienced significant financial deterioration which was no longer in a position to purchase an equity interest which would be accompanied by equity level representation. Nevertheless, the Task Force was able to obtain a local advisory board to provide community input in the operations of the post-closing hospital.

10. On page 20 of the Application, Applicants state that the "post-closing hospital will be governed by a board of directors controlled by PMH (the "Hospital Board"). Please identify the likely composition the Hospital Board, how membership will be determined, the number of proposed directors, whether any current GWHN Board members are expected to serve on the Hospital Board and provide any proposed or actual Bylaws for the Hospital Board.

Response:

The Hospital Board will be composed of executives of PMH and local employed executives of GWHN such as the Chief Executive Officer of GWHN. It is expected that current GWHN Board members would be represented on the Local Board (see Question #11). The number of board members has not yet been determined but in accordance with the APA the Local Board will be between 9 and 12 members. It is PMH's preference that at least one-third of the Local Board members are physicians. There are currently no actual or proposed bylaws for the Hospital Board.

11. On page 91 of the Application and pending further discussions with current GWHN Board, PMH states that it would prefer that at least some of the members of the current GWHN Board agree to serve on the community advisory board ("Local Board") and that a member of the Hospital Board also serve on the Local Board. With respect to this statement, please identify those members of the GWHN Board of Directors who will continue to serve on the Local Board, the member of the Hospital

Board who will serve on the Local Board and provide any proposed or actual Bylaws for the Local Board.

Response:

The discussions regarding the composition of the Local Board are continuing. At this time, the identities of Local Board members are unknown. The Chief Executive Officer of GWHN (a member of the Hospital Board), will be a member of the Local Board. Currently, there are no actual or proposed bylaws for the Local Board.

12. To the extent available, please provide the name and business address for each individual currently serving as a member of the governing body for each entity identified in the Organizational Chart set forth at page 68 of the Application, including, without limitation, PMH, Prospect Provider Groups, Inc. ("PPG") and PHP Holdings, Inc.

Response:

PROSPECT PROVIDER GROUPS, INC.

Chief Executive Officer
Jason Barker

President
Mitchell Lew, M.D.

Chief Financial Officer & Treasurer
Lily Kam

Secretary
Ellen Shin

Senior Vice President
Samuel Lee

Board of Directors
Mitchell Lew, M.D.

PHP HOLDINGS, INC.

Chief Executive Officer, President & Treasurer
Stephen O'Dell

Chief Financial Officer
Brian Werderman

Chief Medical Officer
Arthur Lipper, M.D.

Secretary
Ellen Shin

Senior Vice President
Samuel Lee

Vice President, Compliance
Cheryl Hurst

Board of Directors
Samuel Lee
David Topper
Stephen O'Dell
Mitchell Lew, M.D.
Steve Aleman

PROSPECT HEALTH SERVICES CT, INC.

Chief Executive Officer
Stephen O'Dell

Chief Financial Officer
Brian Werderman

Secretary
Ellen Shin

Senior Vice President
Samuel S. Lee

Board of Directors
Samuel Lee
David Topper
Stephen O'Dell
Mitchell Lew, M.D.
Steve Aleman

PROSPECT PROVIDER GROUP CT – WATERBURY, LLC

Chief Executive Officer
Jason Barker

President
Mitchell Lew, M.D.

Chief Financial Officer & Treasurer
Lily Kam

Secretary
Ellen Shin

Board of Managers
David Pizzuto, M.D. (Chairman)
Earl Bueno, M.D.
J. Michael Elser, M.D.
Fitzhugh Pannill, M.D.
Sagar Phatak, M.D.
Hector Pun, M.D.
Mitchell Lew, M.D. (ex officio)

13. In table format, provide historical volumes (three full fiscal years ("FY") and the current year-to-date) for the number of discharges and patient days, by service for Waterbury Hospital.

Response:

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Discharges:

	FY 2103 Actual 10/12-9/13	FY 2014 Actual 10/13-9/14	FY 2015 Actual 10/14-9/15	YTD 10/15-11/15	FY 2016 Budget FY2016
Medical/surgical	9,548	9,676	9,719	1,662	9,484
Maternity	1,238	1,104	1,156	163	1,135
Psychiatric	1,061	913	771	114	725
Pediatric	0	0	0	0	0
Rehabilitation	0	0	0	0	0
	11,847	**11,693**	**11,646**	**1,939**	**11,344**

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Days:	**FY 2103 Actual 10/12-9/13**	**FY 2014 Actual 10/13-9/14**	**FY 2015 Actual 10/14-9/15**	**YTD 10/15-11/15**	**FY 2016 Budget FY2016**
Medical/surgical	42,489	45,854	43,242	7,442	41,261
Maternity	3,249	3,006	3,101	418	2,989
Psychiatric	9,361	9,222	9,047	1,338	9,394
Pediatric	0	0	0	0	0
Rehabilitation	0	0	0	0	0
	55,099	**58,082**	**55,390**	**9,198**	**53,644**

Initial CON filing projected discharges of 11,699 for FY 2015 (based on annualization of YTD 8/15 actual discharges).

14. Complete the following tables for Waterbury Hospital for the first three (full) fiscal years following the proposed asset purchase, if the first year is a partial year, include that as well.

Response:

TABLE C
PROJECTED DISCHARGES BY SERVICE

Discharges:	**FY 2016 Budget 10/15-9/16**	**FY 2017 Projected 10/16-9/17**	**FY 2018 Projected 10/17-9/18**	**FY 2019 Projected 10/18-9/19**
Medical/surgical	9,578	9,768	10,243	10,755
Maternity	1,146	1,169	1,226	1,287
Psychiatric	733	747	783	823
Pediatric	0	0	0	0
Rehabilitation	0	0	0	0
	11,457	**11,684**	**12,252**	**12,865**
	-2%	2%	5%	5%

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Days:	FY 2016 Budget 10/15-9/16	FY 2017 Projected 10/16-9/17	FY 2018 Projected 10/17-9/18	FY 2019 Projected 10/18-9/19
Medical/surgical	41,670	42,497	44,563	46,791
Maternity	3,018	3,079	3,229	3,389
Psychiatric	9,497	9,678	10,145	10,664
Pediatric	0	0	0	0
Rehabilitation	0	0	0	0
	54,185	**55,254**	**57,937**	**60,844**

a) Explain any increases and/or decreases in historical volumes reported in the tables above.

Response:

The hospital saw a decrease in overall inpatient volume during the course of FY 2015. Some if this decrease may be due to movement of cases from inpatient stays to outpatient observation stays. The budgeted discharge number was based upon this overall lower volume remaining stable into FY 2016.

b) **Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volume**.

Response:

FY 2016: Assumes conversion on April 1st. Overall increase of 3% from 2015 volume for remainder of Year.

FY 2017: Overall increase of 5% from 2015 volume. Physician Recruitment, Care outside of Service Area.

FY 2018: Overall increase of 5% from 2015 volume. Physician Recruitment, Care outside of Service Area.

15. At page 13 of the Application, Applicants describe the Hospital as a "safety net" hospital that treats "a large number of Medicare, Medicaid and uninsured patients." Additionally, Applicants state on page 54, that Waterbury struggles with high unemployment and high poverty. Applicants state that the Asset Purchase will provide access to capital that will allow the Hospital to recruit additional physician and midlevel providers. With respect to these statements, address the following:

a) Describe PMH's experience with the development of its CRC models of care in urban, underserved areas that would demonstrate PMH's ability to effectively grow GWHN's physician network in the Waterbury community.

Response:

PMH is a member of Private Essential Access Community Hospitals ("PEACH"). PEACH is a network of private, core safety net hospitals in California that care for a disproportionate share of low-income, medically vulnerable patients. Despite increased need for services and a host of other challenges, PEACH hospitals remain dedicated to their mission of providing choice and access to high quality, culturally appropriate, and cost-effective health care services to all patients, regardless of ability to pay.

PMH has had experience and success in operating safety net hospitals through the deployment of our CRC model. PMH operates the following safety net hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Norwalk;
- Southern California Hospital at Hollywood;

The payor mix of above hospitals is as follows:

PAYOR MIX	**Southern California Hospital at Hollywood**	**Los Angeles Community Hospital**	**Norwalk Community Hospital**
Medicare	33.8%	12.0%	32.7%
Medi-Cal	10.9%	12.1%	13.9%
Managed Medicare	8.1%	9.4%	10.2%
Managed Medi-Cal	46.0%	63.6%	36.9%

Please note that the above hospitals provide services to primarily the Medicare and Medicaid populations. Also please note that a significant percentage of PMH patients at such hospitals are part of a managed care program. PMH safety net hospitals, above, have full risk arrangements with IPAs that are owned by PMH as well as IPAs that are not owned by PMH. Our collective experience in population health management and understanding the role of hospitals in providing quality and efficient care in a managed care environment attracted other physicians and IPAs to contract with PMH hospitals on a full risk basis despite competing IPAs and the existence of other hospitals in the vicinity of PMH owned hospitals. In other words other physicians and medical groups that wish to participate in a population health management model and who do not wish to be part of PMH find it advantageous to work and collaborate with PMH owned hospitals.

b) Please elaborate on the extent to which GWHN has had difficulty recruiting and/or maintaining medical staff in recent years.

Response:

The average age of the Greater Waterbury Health Network medical staff is about 60 years of age; 20% of the medical staff is within five years of what has been considered the retirement age of 65. The priority recruiting target is primary care which feeds all other specialties. Presently the community could

support at a minimum 16 primary care physicians, not taking into account the number of potential retirements. While GWHN continually is looking for primary care doctors, GWHN has not successfully recruited any practice based primary care physicians in the past four years. GWHN is now actively recruiting for 10 positions. Recruiting hospitalists and psychiatrists in particular has proven to be extremely difficult. Hospitalists are quite mobile and turnover is high, while access to psychiatrists is a significant challenge.

c) Please complete the following table setting forth the number of physicians comprising Active and total members of the medical staff (Active plus all other staff categories) for Waterbury Hospital for the years listed below:

Response:

TABLE E

	2013	**2014**	**2015**
Active Staff	**370**	**339**	**328**
Total Staff	**643**	**614**	**614**

d) **With respect to Waterbury Hospital's medical foundation, Alliance Medical Group, Inc., please provide the number of physicians and other allied health professional participants for each year since the inception of the foundation to the current year to date**.

Response:

	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Professional Staff	83	99	93	96	99	109	112

16. With respect to Exhibits Q42-2 and Q44-1, Applicants project no change in Nurse Staff to Patient Ratios or, in general, the Average Weekly Hours for Ancillary Caregivers for three years following approval of the asset purchase. Reconcile how the asset purchase will achieve efficiencies and improve quality of care without corresponding adjustments to nurse to patient ratios and the hours of ancillary caregivers.

Response:

As we responded to Questions 42 and 44 of the Application**,** staffing ratios in place at GWHN are based on current circumstances and volume and may be updated as appropriate to reflect PMH and industry best practices, and which reflect changes in technology, implementation of the CRC model of coordinated care, and other factors related to the delivery of high quality, cost-effective care. Staffing of Ancillary Caregivers may eventually shift with the implementation of the CRC model, which is expected eventually to result in changes in patient acuity and relative volumes of inpatient and outpatient services.

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. However, it is anticipated that cost and quality improvements will result from improved compliance with existing staffing ratios by implementation of PMH data analytics and operational policies.

Given these limitations, the projections presented in Exhibit Q42-2 (Staffing Attachment II) and Exhibit Q44-1 (Ancillary Caregiver Staffing Attachment) assume volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology will remain constant during the projection period. During the first three full fiscal years following approval of the Asset Purchase (FY 2017, FY 2018, and FY 2019) staffing levels may begin to shift as PMH introduces best practices from its other hospitals and implements its CRC model, which is expected eventually to result in changes in patient acuity caused by improving population health and a shift in relative volumes of inpatient and outpatient services. PMH is committed to staffing levels that comply with ratios mandated by Connecticut state law, which implement best industry practices, and which take into account patient safety and acuity, employee safety and facility census.

17. On page 55 of the Application, Applicants reference utilization of Independent Practice Associations ("IPAs") as part of PMH's overall strategy to improve quality, patient satisfaction and improved patient outcomes. On page 56 of the Application, Applicants state that PMH "has already begun implementation efforts with respect to its CRC model, including formation of an IPA and Board with local representatives, review of regulatory requirements, discussions with payers and evaluation of the care delivery network." With respect to these statements, please address the following:

a) The status on the formation of the IPA and the Board;

Response:

The IPA legal entity has been formed as a limited liability company called Prospect Provider Group CT-GWHN, LLC. ("PPGCTE"). The Chair and the Board of the newly formed IPA are being selected currently and the Board will likely begin to meet in January. Physician contracting will begin as soon as the Board has approved the participating physician agreements.

b) The opportunities and impediments for utilizing the CRC model in Connecticut based on regulatory requirements;

Response:

The primary CRC regulatory requirement for providers assuming and managing value-based risk contracts in Connecticut is licensure as a Preferred Provider Network by the Connecticut Insurance Department. Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015. As such, PMH

has already satisfied the main regulatory requirement necessary for implementing the CRC model in Connecticut.

One potential impediment to fully implementing the CRC model across geographies is the restriction on the number of medical foundation entities per health system that exists under Connecticut law. Specifically, pursuant to §33-182bb(f) of the Connecticut General Statutes, "a hospital, health system or medical school may organize and be a member of no more than one medical foundation." This statutory restriction does not permit the formation of separate medical foundation entities by a hospital system that owns multiple hospitals in wholly separate service areas. This restriction is a significant issue for hospital systems that operate in more than one market in that third party payers typically set contract rates, adjudicate claims or limit participation in certain risk sharing arrangements or incentives based on service area. PMH is seeking approval to own three hospitals in two different markets but will have to utilize a single medical foundation even though the professionals employed in the medical foundation will be in two distinct markets. In order to participate in regionalized payer contracts or programs, a medical foundation formed by PMH will need to work with payers to allocate providers under different risk arrangements while maintaining a single tax identification number. Many payors do not have ready systems that can allocate providers to divisions within a single tax identification number, making population health management and risk-based contracting more difficult. There is no easy immediate solution to this problem, and PMH plans to try to work closely with payers to develop internal tracking mechanisms by the payer and PMH. However these unnecessary added administrative costs may defeat some of the healthcare savings of the risk model.

c) The substance and status of discussions with payers; and

Response:

PMH has had preliminary discussions with most of the major payers in Connecticut to introduce PMH's CRC model to them. They have all expressed the desire to work with PMH on value-based contracts such as those preferred in PMH's CRC model. To date, the discussions with payers have been introductory, rather than substantive. However, PMH is optimistic that the discussions will result in most payers embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

d) Any reports on PMH's evaluation of the care delivery network.

Response:

PMH does not have any written evaluations of the care delivery network. However, PMH filed an application for the Preferred Provider Network as a substantial component of the delivery network and PMH received its PPN license in October 2015. . PMH is pleased with GWHN's care delivery network and believes it will provide a substantial foundation for PMH's CRC model in the service area.

18. On page 65 of the Application, Applicants disclose that "PMH and GWHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients." Please provide an update on the status of these discussions. What impact, if any, would there be on the proposed asset purchase if Connecticut's Department of Social Services were to decide not to enter into risk-based arrangements with PMH?

Response:

Since the initial meeting with the Department of Social Services, PMH has not met with representatives of that Department. PMH expects to meet with the Department in the near future. The Applicants would be disappointed if the Department of Social Services decided not to enter into a risk-based arrangement with PMH (since it will not only reduce overall costs to the State of Connecticut, but improve population health as well), but it would not have an impact on the proposed asset purchase.

19. Applicants assert on page 46 of the Application, "where Prospect has acquired hospitals [in California, Rhode Island, and Texas], the access and quality of care improved, significant capital investments were and are continuing to be made, and job growth has occurred." At page 64 of the Application, Applicants state that "[i]t is anticipated, over time, that Prospect will achieve improvements in access and the quality of services available" to Medicaid recipients and the indigent. Please cite to specific examples at other PMH acquired hospitals to address the following:

a) How access and quality of care has improved for patients in general and Medicaid and indigent patients in particular (identify the standards or benchmarks demonstrating these improvements); and

Response:

In order for the CRC model to be successful, we must continually strive to increase access to care and the quality of care. After purchasing the Nix system in Texas, we accomplished the following:

(i) Opened an Emergency Room. Prior to the acquisition of Nix by PMH, Nix did not have an emergency room. The Emergency Room provides services to all patients who present themselves without regard to ability to pay including Medicaid and the indigent;

(ii) Expanded Nix's behavioral beds by leasing a new facility. This behavioral facility provides both psychiatric evaluation services as well as critical evaluation services to patients including Medicaid and the indigent population.

(iii) Purchased a critical access hospital in rural communities surrounding San Antonio that would have closed had PMH not purchased this facility. In addition to purchasing this hospital, PMH has established a number of clinics surrounding the critical access hospital in order to increase the access to care.

In Rhode Island we have either achieved or committed to the following:

(i) Proposed a pilot program in the state of Rhode Island to manage the health of 25,000 Medicaid patients at a cost savings to the state of Rhode Island. The implementation of

such program necessarily requires that we have appropriate access and provide quality care to such population. We believe that this proposal exemplifies PMH's commitment to provide healthcare services to all patients, irrespective of payor. It should be noted that PMH is prepared to work with the state of Connecticut on a similar proposal to manage a segment of the Medicaid population in Connecticut at cost savings to the State.

(ii) PMH has committed to expanding the emergency rooms at both hospitals in Rhode Island. In case of Roger Williams we are increasing the number of emergency beds in order to better service the needs of our patient population.

(iii) PMH has filed Certificate of Need applications in Rhode Island in order to open a new Cardiac Cath Lab and for Obstetrics services.

(iv) In order to enhance the patient experience, we are modernizing certain areas of the hospitals over the next two years.

(v) PMH has also committed to expanding and enhancing CharteCARE's outpatient physical therapy space and services; and

(vi) In partnership with other areas hospital in Rhode Island invested in a radiation therapy center.

At CharterCARE, local management and physicians have decided to become a high reliability healthcare organization as recommended by The Joint Commission. PMH is dedicating financial resources of hiring consultants and other personnel necessary in order to transform CharterCARE to excel in providing safe and effective care of the highest quality by earning and maintaining The Joint Commission's Gold Seal of Approval™, a symbol of quality that is recognized nationwide and reflects an organization's commitment to meeting demanding performance standards. Some of the goals of high reliability care are:

- Improve organizational effectiveness;
- Improve organizational efficiency;
- Improve customer satisfaction;
- Improve compliance;
- Improve organizational culture; and
- Improve documentation.

b) Provide details regarding significant capital investments initiated by PMH at the hospitals it has acquired within 5 years post-closing.

Response:

Hospital	Investments since Acquisition	
Los Angeles Community Hospital at Bellflower	$ 3,646,633	(a)
Foothill Regional Medical Center	$ 7,912,807	(a)
Our Lady of Fatima Hospital	$ 11,321,376	(b)
Roger Williams Medical Center	$ 11,321,376	(b)
Nix Health System	$ 33,350,077	

(a) Both Los Angeles Community Hospital at Bellflower ("Bellflower") and Foothill Regional Medical Center ("Foothill") were closed prior to PMH acquisition. Bellflower re-opened in July 2015 and Foothill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Total capital investment in Our Lady of Fatima and Roger Williams Medical Center, (which comprise CharterCARE), is reported on a combined basis. In addition to the amount already spent, we have committed to spend $20 million on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department) and (iv) physician practice acquisitions.

20. On pages 57 and 59 of the Application, PMH references the development and implementation of specific programs executed through its CRC model designed to address patients with significant co-morbidities. Please describe these programs in detail and explain how they will be implemented within the Greater Waterbury community. Provide detail on how quality of care and cost effectiveness of care has been improved as a result of these programs.

Response:

PMH has specific medical management programs depending on the setting of the patient at the time of care. For example, PMH has programs for patients with significant co-morbidities a home, in a hospital, in a sub-acute setting or in long term care setting. The specifics of each program are described below.

Utilizing its medical management programs, PMH provides the following services to high risk patients with significant co-morbidities at home:

- 24/7 Direct Telephonic Access
- Identification of patient "admission drivers" with development of specific actions plans
- Patient and Family Engagement of Care Plans
- Integrated Social Service coordination for members with psychosocial issues and placement issues
- Integrated Behavioral Health Management
- Disease Specific Action Plans and Self-Management
- Advance Care Planning
- Coordination of Ancillary Services/Physician Referrals
- Outpatient Palliative Care Program
- Multidisciplinary team of physicians, nurses, social workers chaplain, & pharmacist available 24/7
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, & Cellulitis
- Hospital post-DC follow-up visits within 24 hr.
- Same day urgent visits
- Phone Communication with primary care physician and specialist for intervention
- Telephonic Medication Therapy Management
- Disease Management Programs (DM & Anticoagulation)
- Post DC In-Home Medication Therapy Management
- LTC Medication Therapy Management
- Integrated with Inpatient & Outpatient Clinical Teams
- Patient Education and Assessment of Non Adherence

The Objectives of the above programs are to manage symptoms and reduce hospital readmits with the goal of maximizing care in the home.

When high-risk patients with significant co-morbidities are admitted to a hospital, PMH's hospital care management program provides the following:

- Expectation of close monitoring of patients by rounding 2x per day until patient is discharged
- Medical Director rounds with hospital case manager and hospitalist twice per day until the patient is discharged
- Ability to direct patients from acute setting to Skilled Nursing Facility when appropriate;
- Ability to direct patients from acute setting to early post discharge visits when appropriate; and
- Close collaboration between hospital case manager, skilled nursing facility case manager, pharmacist, nurse practitioner and primary care physician

When high risk patients with significant co-morbidities are in a sub-acute setting, PMH's medical management program provides the following:

- Monitoring of patients by rounding 3-5x per week until patient is stable, then 2-3x per week
- Physician rounds supplemented by Prospect nurse practitioners
- Medical Director rounds with case managers and physician 2x per week; and
- If patient's status deteriorates, transfer to network hospital

With respect to the quality and effectiveness of these programs please see question #21.

21. On page 62 of the Application, Applicants state that through the CRC model, "PMH has demonstrated improved clinical outcomes, higher quality scores, higher patient satisfaction, lower re-admission rates, lower average lengths of stay, and lower medical-cost ratios." Provide specific examples in addition to those cited on pages 65-66 and include all assessments, reports, analysis or any other documentation supporting these claims.

Response:

With respect to quality of care, our medical group segment has received the awards:

1. California Association of Physician Groups (CAPG) standards of excellence program "Elite Status" 4 years in a row (2012 - 2015)
2. Integrated Healthcare Association (IHA) recognition of outstanding performance: "Meaningful Use of Health IT" and "Clinical Quality"
3. Silver and Bronze awards from the State of California (DMHC) for excellence in cardiovascular care, cholesterol control and diabetes care

Our CRC model is most mature in the senior population. The medical cost ratio associated with hospital care for the senior population was 103.9% in 2012. Through the implementation of the programs noted in question #20 above, the medical cost ratio associated with hospital care for the senior population was 90.3% in 2013 and 80% in 2014. For 2015, we expect similar results as 2014.

22. In connection with Section 6.09 of the APA, at page 189 of the Application, please respond to the following questions:

a) Section 6.09 provides that PMH will "ensure that the Hospital maintains and adheres to Seller's current policies on charity care…for at least five (5) years from Closing." In the ECHN Transaction, PMH did not qualify its commitment to continue ECHN's charity policies. Please explain the parties' decision to agree to this qualification.

Response:

First, it should be noted that GWHN negotiated a deal separate and apart from ECHN. Each deal stands on its own. Neither GWHN nor ECHN were privy to the other's negotiations. The GWHN board negotiated a deal (taking the transaction as a whole) that it believed was in the best interests of GWHN and its surrounding communities.

Finally, when PMH and GWHN renewed their negotiations in early 2015, the Board of GWHN requested that PMH agree to the economic terms and conditions that it had previously negotiated with Vanguard / Tenet which had already been approved by (i) the Board of directors of GWHN; (ii) OHCA; and (iii) the Attorney General of Connecticut. No changes were made to section 6.09 of the APA.

It should also be noted that ECHN had made a similar request as GWHN from PMH with respect to maintaining the economic terms and conditions that ECHN had already negotiated with Tenet/Vanguard.. Since ECHN had already negotiated a deal with Vanguard / Tenet which had already been approved by its board of directors, very few changes were made to the definitive documents of the ECHN Transaction. Similar to this transaction Section 5.16 of the Asset Purchase Agreement to the ECHN transaction was not changed from the previously negotiated Vanguard / Tenet transaction.

b) Section 6.09 of the APA, at page 189 of the Application, also provides that PMH will participate in Medicare and Medicaid, accept all emergency patients without regard to ability to pay, provide public health programs and promote public health for at least five years after Closing. Particularly in view of Waterbury Hospital's current status as a "safety net" hospital, please discuss how access to care in the community will be affected if PMH ceases GWHN's participation in Medicare and Medicaid no longer accepts all emergency patients without regard to ability to pay or no longer continues to operate under the Hospital's charity care policies.

Response:

Health care is in a state of flux particularly after the passage of the Affordable Care Act. It is difficult, if not impossible, to accurately predict the effect on access to care in the unlikely event that PMH would withdraw from Medicare or Medicaid, or if it no longer accepts all emergency patients without regard to ability to pay, or no longer operates the Hospital's charity care policies in 5 years. As a practical matter, PMH is making a substantial investment in Waterbury and its community, and it is extremely unlikely that it would ever withdraw from the Medicare or Medicaid programs, and it is required by federal law ("EMTALA") to treat all emergency patients without regard to ability to pay.

It should be noted that PMH (i) participates in Medicare and Medicaid programs; (ii) accepts emergency patients without regard to ability to pay; and (iii) maintains charity care policies at all of its hospitals even though it is under no obligation to do so. PMH believes that providing charity care is the responsibility of all healthcare providers. In fact, Prospect is a member of Private Essential Access Community Hospitals ("PEACH"). PEACH is a network of private, core safety net hospitals in California that care for disproportionate share of low-income, medically vulnerable patients.

23. Reference is made to Table F concerning the amount of uncompensated care provided by Waterbury Hospital from FY 2012 to FY 2014:

TABLE F

	FY 2012	FY 2013	FY 2014
Charity Care	**$1,389,352**	**$1,472,594**	**$5,644,280**
Bad Debts	**$10,435,502**	**$10,783,760**	**$3,692,986**

*** Source: OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept. 2015)**

a) Please explain the reasons for the large increase in charity care provided by the Hospital in FY 2014.

Response:

Effective October, 2013, the Hospital's charity care policy was changed. As of this date, the policy is that patients who do not apply for or do not qualify for charity care are expected to pay the balance due. For uninsured patients, this is equivalent to 50% of charges.

b) Please explain the reasons for the large decrease in bad debt recognized by the Hospital in FY 2014.

Response:

The large decrease in the bad debt is directly related to the change in the charity care policy as discussed above.

c) Provide the amounts of charity care provided by Waterbury Hospital and the amount of bad debt recognized for FY 2015.

Response:

For FY 2015 Waterbury provided $5,323,038 in charity care and recorded $3,747,762 in bad debts.

d) Please describe how the proposed asset purchase with PMH can result in an increase in charity care provided by Waterbury Hospital and cite to any examples from PMH's prior non-profit acute care hospital acquisitions where the amount of charity care (not total uncompensated care inclusive of bad debt) has increased from year to year post acquisition.

Response:

With the passage and implementation of the ACA, the amount of charity care for the industry as whole has been declining. As more people are insured, the need for charity care has decreased. PMH remains

committed to providing charity care and to maintaining the charity care policies of Waterbury Hospital in accordance with the APA.

24. Subsequent to acquisition of both hospitals, describe PMH's experience in implementing the Community Health Needs Assessment ("CHNA") implementation strategies for both Roger Williams Medical Center and Our Lady of Fatima Hospital. Please describe the priority needs identified in each CHNA and how each hospital is presently addressing those needs.

Response:

As a for-profit entity, PMH was not required to participate in CHNAs which generally are intended to support a not-for-profit hospital's charitable mission and assure maintenance of its not-for-profit status. However, PMH works closely with its Local community advisory Boards (comprised of local physicians and community leaders) to help assess local community needs and develop effective plans to address such needs.

25. On page 62 of the Application, PMH commits to "support the priority needs identified by the CHNA" developed by Waterbury Hospital in collaboration with the Greater Waterbury Health Improvement Partnership ("GWHIP"). With respect to this statement, please respond to the following:

a) On page 924 of the Application, the Certificate of Incorporation for the Independent Foundation states that as part of its purpose, the Foundation will conduct or support CHNAs. Please compare and contrast the Foundation's role in conducting and supporting CHNAs with those of Waterbury Hospital if it becomes a for-profit hospital.

Response:

Waterbury Hospital has a tradition of taking a lead role in developing and rolling out the bi-annual community health needs assessment (CHNA). As a healthcare provider of both outpatient and acute care services in the future, regardless of its nonprofit to for profit status, the health of the community will remain a priority for WH. As discussed with Prospect, GWHN and Waterbury Hospital will remain engaged in a leadership role in the CHNA. Key professionals on staff at GWHN will remain personally and professionally involved in CHNA efforts. The Independent Foundation has the charitable purpose and corporate power to amend and support CHNAs.

b) Please address the extent to which Waterbury Hospital will continue to participate in the GWHIP after the closing and whether it intends to adopt implementation strategies to address health needs identified in CHNAs for the Waterbury area that would be conducted post-closing.

Response:

PMH will support and implement Waterbury's CHNA plans through 2016. For subsequent years, PMH will work closely with Waterbury's Local Advisory Boards (comprised of local leaders and physicians) to help assess local community needs and develop effective plans to address such needs.

c) On page 1119 of the Application, the CHNA findings of GWHIP identified additional key community health issues, including addressing Diabetes, Heart Disease, Respiratory Disease, Infant Mortality/Low Birth Rate and Cancer. Please elaborate on how PMH plans to address these additional areas of need in the Greater Waterbury area.

Response:

PMH will continue to evaluate the healthcare needs of the community as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. Plans to address the priority needs in Waterbury's service area will be developed post-closing once the priority needs have been confirmed or identified.

26. Reference is made to Exhibit Q51-1, the Hospital's IRS Form 990 Report for the 2014 Tax Year. Please detail all charitable donations and other monetary and non-monetary support provided by Waterbury Hospital to the following programs and/or services and comment on the extent to which they will be continued by the post-closing hospital:

a) Waterbury Hospital Infectious Disease Clinic

Response:

FY14 WH Monetary Support- $108,875.00 (Salaries/Fringe Benefits)
WH Non-monetary Support- $470,900.00 (In-kind: Indirect Costs-Based on the DHHS Approved Indirect Cost Rate of 36%)
Restricted Grants- $1,463,920.00

b) Waterbury Health Access Program

Response:

FY14 WH Monetary Support- $18,667.00 (Salaries/Fringe Benefits)
WH Non-monetary Support- $125,386.00 (In-kind: Indirect Costs-Based on the DHHS Approved Indirect Cost Rate of 36%)
Restricted Grants/Contributions- $402,864.00

c) Waterbury Hospital Center for Behavioral Health

Response:

DEPARTMENT OF MENTAL HEALTH AND ADDICTIONS GRANTS
FY 15

Acute Inpatient Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$123,815
Income:	DMHAS Grant Dollars	$101,661
	Waterbury Hospital Contribution -	$ 22,154

Crisis Center Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$1,659,408
Income:	DMHAS Grant Dollars	$ 897,886
	Reimbursement	$ 34,897
	Waterbury Hospital Contribution	$ 726,625

DBT/IOP Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$ 256,305
Income:	DMHAS Grant Dollars	$ 50,301
	Reimbursement	$ 167,176
	Waterbury Hospital Contribution	$ 38,828

Adult Outpatient Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$1,157,446
Income:	DMHAS Grant Dollars	$ 303,477
	Reimbursement	$ 456,207
	Waterbury Hospital Contribution	$ 397,762

Homeless Outreach Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$ 176,988
Income:	DMHAS Grant Dollars	$ 151,435
	Waterbury Hospital Contribution	$ 25,553

Outpatient Expansion Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$ 254,431
Income:	DMHAS Grant Dollars	$ 198,657
	Reimbursement	$ 40,616
	Waterbury Hospital Contribution	$ 15,158

Respite Grant:

Expenses:	Salaries, Fringes, Direct and Indirect Operating	$ 118,770
Income:	DMHAS Grant Dollars	$ 121,163
	Waterbury Hospital Contribution	$ 2,393

Grand Total:		
Expenses:	**Salaries, Fringes, Direct and Indirect Operating**	**$3,747,163**
Income:	**DMHAS Grant Dollars**	**$1,824,580**
	Reimbursement	**$ 698,896**
	Waterbury Hospital Contribution	**$ 1,223,687**

d) Be Well Bus

Response:

The cost of the Be Well Bus for FY 15 was $90,636

e) Heart Center of Greater Waterbury

Response:

Payments to Heart Center of Greater Waterbury - $113,226

f) Family Birthing Center

Response:

The Family Birthing Center is a department of Waterbury Hospital that provides maternity and childbirth services. The expenses associated with the classes for expectant parents are incorporated into the budget for this department. The Hospital spent **$4,125 in FY 2015** for Education (including materials and books). The Hospital collected **$2,888** in revenue for wellness programs.

This leaves a **net contribution by the Hospital of $1,237.**

g) Thank God I'm Female

Response:

The Hospital's contribution in **FY 2015 was $10,001**.

h) Evergreen 50 Club

Response:

The Hospital's Net Contribution in **FY 2015 was $26,771.**

PMH will evaluate the above programs and the healthcare needs of the community and will prioritize its capital and other projects based on hospital and community needs. The goal will be to establish a coordinated care model by providing quality healthcare services and providing access to needed services to all segments of the population (including the Medicaid population and the indigent). Decision regarding the above programs will be made post-closing.

27. The Application at page 84 states that PMH will be seeking property and sales tax abatements post-closing for a transition period and that "such abatement is deemed critical to the overall success of the proposed transaction." In connection with these statements:

a) Please describe the length of the proposed transition period and the particulars of the abatement that will be sought.

Response:

As a for-profit health system, PMH will be expected to pay property taxes, sales taxes and income taxes post-closing. Even though PMH does not have the benefits of tax-exemption, PMH has committed to maintain and adhere to GWHN's current policies regarding charity care, indigent care and has agreed to provide public health programs of educational benefit to the Community and generally promote public health, wellness and welfare to the community by operation the Hospital with quality standards. In essence, PMH is not only required to provide the benefits generally expected from non-profit hospital operators, but is also required to pay the taxes described above even though similarly situated hospital operators would not be responsible for such taxes.

Although PMH expects that implementation of the CRC model will result in an improved financial outlook for the current GWHN operations, these benefits will take time to realize. If taxes are imposed on PMH before any of these benefits can be obtained, there is a risk that the new tax burden could negatively affect the community in terms of jobs, local vendor payments and other factors which could outweigh the benefits from tax collections. Accordingly, PMH plans to work with the State and local communities to seek temporary relief from the new tax burden. This temporary relief has been deemed appropriate in other states in order to allow a hospital to re-gain its strength for the benefit of its employees and the communities that it serves before taking on the full tax burden.

Seeking temporary tax relief is a process that necessarily involves the participation of all constituents. PMH is aware of pilot programs where cities receive funds from the State because they host non-profit entities. PMH is in the process of gathering facts that are necessary to formulate a fair proposal for all parties. As such, PMH, at this time, does not have any specific proposals that it can share. PMH will update this response once it has made progress with state and local community representatives responsible for coordinating the tax programs.

b) Explain why the abatement is deemed critical to the overall success of the proposed transaction.

Response:

Please refer to the response to Question 27a) above for the Applicant's explanation regarding the need for the abatements post-closing.

c) If PMH is unsuccessful in its negotiations for such an abatement, will there be any changes to the Capital Commitment or PMH's commitment as noted on page 84 to adhere to GWHN's current policies regarding charity care, indigent care, community volunteer services and community benefits?

Response:

PMH is proud of its history of providing health care services to underserved communities. PMH hopes that it will be able to negotiate a fair tax abatement plan that will place all healthcare providers on equal competitive grounds. However, in the event that PMH is not successful in those negotiations, PMH will continue to honor all of its obligations under the APA (including but not limited to the Commitment Amount), to maintain GWHN's current policies regarding charity care and indigent care. .

28. Reference is made to Table 1 on page 74 of the Application. Please explain the assumptions behind the projected reduction in the number of self-pay discharges for FYs 2016-2018.

Response:

Medicaid expansion and the availability of low-cost insurance plans through the Health Insurance Exchange (created as a result of the Affordable Care Act) have reduced the number of uninsured patients.

29. Please elaborate on the expected revenue growth for Waterbury Hospital associated with the use of the CRC model of care and provide specific examples from hospitals currently owned by PMH of actual savings realized post-acquisition in the various operating expense categories set forth in Financial Worksheet (C).

Response:

The implementation of CRC is not expected to cause a reduction in operating expense categories. CRC's goal is to reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC achieves these objectives by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs, and by keeping patients healthier so as to reduce the overall over-utilization of healthcare services. By achieving these objectives, the cost of healthcare will be reduced for all stakeholders including Medicare and Medicaid programs.

In the state of Rhode Island, PMH projects to reduce the cost of care for a segment of the Medicaid population by 5%.

30. On page 69 of the Application, the Applicants indicate that "PMH has access to an existing corporate level credit facility in addition to its cash on hand." Name the credit facility, provide PMH's current credit rating and elaborate on the process associated with borrowing funds from this credit facility to fund any portion of the $51.5 million Capital Commitment in lieu of cash from GWHN operations.

Response:

PMH has received credit upgrades by both Moody's and S&P in 2015. Moody's rates PMH's bonds as "B1," while S&P rates PMH's bonds as "B."

PMH has access to a revolving line of credit with Morgan Stanley that has been pre-approved. In order to draw on this line, PMH simply provides a 24 hour advance verbal notice to the lenders. The line of credit is available to fund the Commitment Amount if necessary.

31. Elaborate on the financial feasibility to fund the $53 million purchase price given PMH's declines in cash and cash equivalents, operating income, net income, and realized deficits in Stockholder's equity from FY 2012 to 2014 reported in its FY 2014 audited financial statements as set forth at Exhibit Q8-1.

Response:

PMH's financial performance has demonstrated significant growth from 2012 to present:

PMH Financial Performance	2012	FYE 09/30/2015
Operating Income:	$80 Million	$108.1 Million
Net Income	$26 Million	$34.3 Million
Stockholders' Equity	$31 Million	$36.4 Million

The growth in Stockholders' Equity is net of a $100 million dividend paid in November 2012. Please refer to Exhibit Q8-2 of the CON application for more information pertaining PMH's stockholder equity.

Impacting 2014 reported financial and cash flow was the delay in revenue recognition of the California Quality Assurance Fee (SB 239) program. The associated revenue, EBITA and cash receipts could not be recognized until formal Federal approval of the program was received which occurred after the fiscal year-end.

Cash balances from 2012 to 2014 were impacted by the completion of multiple acquisitions paid with existing cash on the balance sheets. The cash consideration for these acquisitions totaled in excess of $81 million. Additionally, during this time, the Due from Government payor receivable increased by more than $28 million, primarily due to the delay in funding the California Quality Assurance Fee

program for the period of January 2014 to September 2014. Payments related to this program were subsequently received in 2015.

PMH has significant cash on hand to complete the transaction. PMH on consolidated basis has in excess of $110 million in funds available. Furthermore, PMH generates over $7.5 million in free cash flow per month. The amount of cash necessary to close the GWHN transaction after assumption of liabilities (including pension liabilities) is currently estimated to be approximately $4 million.

32. Provide an updated Pro Forma Balance Sheet for the proposed Transaction, Exhibit Q3-3 at page 221, as of September 30, 2015.

Response:

Please see Response to Question 7a.

33. In reference to Financial Worksheet (C), Exhibit Q37-1, and the related Assumptions, at Exhibit Q38-1, for GWHN and Waterbury Hospital address the following:

a) For GWHN, provide a revised Financial Worksheet (C) that will include Actual results for FY 2014. Note that the results reported must agree with the GWHN audited financial statements filed at OHCA. Provide the missing assumptions utilized in developing the projections and explain any projected losses from operations;

Response:

Item # 33a			Greater Waterbury Health Network			
		Per CON	Per 2014 Audited F/S	Variance		
Net Patient Revenue		248,588,440	248,939,189	350,749		
Operating Expenses		274,042,856	268,450,195	(5,592,661)		
Net Income (Loss)		(4,678,016)	(4,728,011)	(49,995)		
Net Income:						
Greater Waterbury Management Resources Loss			34,250			
Children's Center of Greater Waterbury Loss			14,787			
			49,037			
			(49,995)			
Audit adjustments made after year end			(958)			
Operating Expenses:						
Waterbury Hospital		227,749,078	216,453,290	(11,295,788)	AMG and CAGW losses	
GWIC		2,917,354	2,917,229	(125)		
Access Rehab		10,044,797	10,044,756	(41)		
Imaging Partners		50,694	50,694	-		
AMG		20,799,609	29,103,055	8,303,446	Loss of $8,152,669 plus provision for income taxes of $150,777	
CAGW		8,159,105	11,302,221	3,143,116	Loss rolled up to Waterbury Hospital	
VNA		4,254,039	4,254,039	-		
GWMR		-	-	-		
Children's Center		-	1,770,632	1,770,632	Not included in CON	
GWHN		68,181	69,142	961	Audit Adjustment after year end	
Eliminations on Waterbury Hospital F/S		-	(7,456,104)	(7,456,104)		
Eliminations on GWHN F/S		-	(58,759)	(58,759)		
				(5,592,662)		
Net Patient Revenue:						
Waterbury Hospital		208,626,652	208,626,652	-		
GWIC		4,439,791	4,439,666	(125)		
Access Rehab		8,230,315	11,038,847	2,808,532		
Imaging Partners		-	1,691	1,691		
AMG		16,354,898	16,354,899	1		
CAGW		6,397,091	6,397,091	-		
VNA		4,539,692	4,539,692	-		
GWMR		-	-	-		
Children's Center		-	-	-		
GWHN		-	-	-		
Eliminations on Waterbury Hospital F/S			(2,459,349)	(2,459,349)		
				350,750		
Access Rehab Centers:						
1,286,157	Income-Contract Services Inpatient		Does not get billed to an insurance			
301,920	Income-Contract Mgmt. Services					
1,206,622	Income-Contract Services Outpatient					
13,833	Miscellaneous Income					
2,808,532	Included in Other Operating Revenue on CON					
(82,075)	Lab fees, laundry, rent, etc					
(34,777)	Marketing, rent to AMG					
(1,189)	Rent owed to Access Rehab					
(220,656)	Rehab services billed owed to Access Rehab					
(10,234)	Dividend income					
(2,541)	Mattatuck Medical Investment income					
722	Other Income/Expense					
(350,750)						
For the assumptions, we estimated expenses for FY 2017 and FY 2018 based on general expense assumptions by major category.						
The losses come from the fact that the renegotiated contracts that generated additional net revenue for FY 2016 will						
start to level off in the later years of the projections.						

b) For Waterbury Hospital, provide a revised Financial Worksheet (C) that will include FY 2014 Actual results in agreement with the audited financial statements filed at OHCA. Explain the zero amounts reported under the uninsured, self-pay and workers compensation line items.

Response:

The Hospital had requested clarification from OHCA on this question, and it was agreed that a reconciliation of the reported data to the audited financials would be acceptable. Reconciliation is below – it is noted that with the CON financials we have reported a net income of $0 for both Alliance Medical Group and Cardiology Associates of Greater Waterbury, as the losses for these two hospital affiliates are subsidized by the Hospital.

The Hospital has listed nongovernment net revenue on one line, to be consistent with how we are reporting the projections. The non-governmental net revenue by specific payers is not usually finalized until the OHCA filing is completed, so we do not have the FY 2015 final net revenue by specific payer (with allocation of charity care, bad debts, etc.)

		Waterbury Hospital	
	Per Con	**Per 2014 Audited F/S**	**Variance**
Net Patient Revenue	208,626,652	208,626,652	-
Operating Expenses	227,749,078	216,453,290	(11,295,788)
Net Income (Loss)	(7,772,011)	3,523,777	11,295,788
AMG Loss (per AFS)		8,152,669	
Cardiology Associates Loss (per AFS)		3,143,116	
		11,295,785	

c) Explain the zero incremental amounts associated with this proposal for Waterbury Hospital when the assumptions submitted indicate increases in revenue, volume, and expenses for FY 2016.

Response:

The overall inpatient volume for FY 2016 is projected to be less than FY 2015 actual. Overall FY 2016 outpatient volume is projected to increase by 2% from FY 2015 to FY 2016, and then remain constant over the next two years. The net revenue for FY 2016 is calculated based on the change in volume indicated above, along with increases in revenue due to renegotiated rate increases for specific commercial payers and also an overall increase in the base rate for Medicare inpatients.

For the other hospital affiliates, we have consistently reflected increases in volume, net revenue and expenses.

d) For GWHN and Waterbury Hospital, explain why the applicants assumed increases in expenses, for FY 2016-FY 2018, when in response to questions 26 and 53, the Applicants indicate that they expect a lower cost structure and improved efficiencies

that will generate cost savings and that, as stated in Exhibit Q38-1, "*the hospital engaged the Camden Group to look at opportunities to remove expenses from the organization and we have begun or about to begin implementing many of these based on the data analyzed. Our goal moving forward and starting in FY 2016 is to increase our revenue capability but also make significant changes that will allow us to decrease our expenses where appropriate.*"

Response:

The Hospital has built into its FY 2016 budget expected expense reduction due to both Camden Group and internal expense reduction initiatives. This reduced budgeted FY 2016 expense base is the basis for projections for FY 2017 and FY 2018.

e) Explain the Applicants submission of Alliance Medical Group's assumptions as a separate entity and their relationship with the Financial Worksheets(C).

Response:

Alliance Medical Group is a wholly owned subsidiary of GWHN. The FY 2016 numbers are from the AMG budget for 2016 with slight increases in volume for the addition of primary care physicians. The annual subsidy for AMG is included in the Hospital's profit and loss statement as an expense on Worksheet C.

34. Please provide updated Financial Measurements/Indicators, Exhibit Q50-1, for the months of July, August and September 2015 and comparable months from the previous fiscal year for GWHN, Waterbury Hospital and PMH. Provide the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015.

Response:

Waterbury Hospital Only	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15	Month of Sep-14	Y-T-D 09/30/14	Month of Sep-15	Y-T-D 09/30/15
A. Operating Performance												
Operating Margin	-1.23%	-0.06%	-18.30%	-3.40%	-3.87%	-0.40%	-10.44%	-4.01%	6.34%	0.18%	-37.28%	-5.91%
Non-Operating Margin	-0.22%	1.40%	-17.27%	-2.20%	-2.41%	1.06%	-9.51%	-2.83%	7.20%	1.59%	-35.16%	-4.68%
Total Margin	-0.19%	1.43%	-17.34%	-2.16%	-2.36%	1.10%	-9.58%	-2.80%	7.27%	1.63%	-38.19%	-4.82%
Bad Debt as % Gross Revenue	-3.18%	0.09%	1.03%	0.35%	0.77%	0.15%	0.86%	0.39%	3.19%	0.41%	0.58%	0.41%
B. Liquidity												
Current Ratio	1.73	1.73	1.53	1.53	1.91	1.91	1.56	1.56	1.70	1.70	1.27	1.27
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66	70.07	70.07	48.2	48.20
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94	47.90	47.9	60.73	60.73
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69	54.38	54.38	58.9	58.90
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.9083	1.9083	-23.7088	-23.7088	2.0337	2.0337	-6.2679	-6.2679	2.1620	2.1620	-2.8563	-2.8563
Long-term Debt to Capitalization	0.6562	0.6562	1.0440	1.0440	0.6704	0.6704	1.1898	1.1898	0.6837	0.6837	1.5387	1.5387
Unrestricted Cash to Debt	0.7582	0.7582	0.3218	0.3218	0.6156	0.6156	0.2694	0.2694	1.0347	1.0347	0.5303	0.5303
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31	1.55	1.55	-10.27	-10.27
Equity Financing Ratio	5.81	5.81	-76.40	-76.40	5.95	5.95	-20.33	-20.33	7.10	7.10	-9.14	-9.14
D. Additional Statistics												
Income from Operations	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(643,631)	1,907,078	8,667,899	(2,987,821)	(3,631,452)
Revenue Over/(Under) Expense	(35,827)	2,588,543	(2,772,128)	(3,707,507)	(416,695)	2,171,848	(1,547,662)	(5,255,169)	1,358,560	3,530,414	(4,350,148)	(9,605,317)
Patient Cash Collected	16,953,790	173,216,936	17,588,030	165,780,926	16,391,215	189,608,151	16,367,950	182,148,876	19,856,343	209,464,494	17,283,378	199,432,254
Cash and Cash Equivalents	20,457,074	20,457,074	8,257,373	8,257,373	16,563,273	16,563,273	6,880,235	6,880,235	27,540,954	27,540,954	16,284,244	16,284,244
Net Working Capital	22,842,265	22,842,265	15,242,354	15,242,354	25,043,856	25,043,856	16,052,250	16,052,250	24,599,297	24,599,297	10,506,595	10,506,595
Unrestricted Assets	13,704,068	13,704,068	(1,045,742)	(1,045,742)	12,825,022	12,825,022	(3,936,749)	(3,936,749)	11,890,055	11,890,055	(10,064,752)	(10,064,752)
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15	Month of Sep-14	Y-T-D 09/30/14	Month of Sep-15	Y-T-D 09/30/15
A. Operating Performance												
Operating Margin	-4.04%	-3.03%	-20.71%	-6.77%	-6.81%	-3.31%	-14.10%	-7.39%	-3.34%	-3.31%	-37.39%	-9.24%
Non-Operating Margin	-3.17%	-1.80%	-19.90%	-5.81%	-5.61%	-2.12%	-13.35%	-6.45%	-2.61%	-2.16%	-35.83%	-8.26%
Total Margin	-3.72%	-1.62%	-19.53%	-5.97%	-4.63%	-1.88%	-15.30%	-6.77%	-4.02%	-2.06%	-38.92%	-8.75%
Bad Debt as % Gross Revenue	-2.80%	0.16%	1.02%	0.39%	0.79%	0.21%	0.85%	0.43%	2.98%	0.45%	0.61%	0.45%
B. Liquidity												
Current Ratio	1.68	1.68	0.97	0.97	1.79	1.79	1.03	1.03	1.60	1.60	1.17	1.17
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66	70.07	70.07	48.20	48.20
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94	47.90	47.90	60.73	60.73
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69	54.38	54.38	58.90	58.90
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.7431	0.7431	1.5119	1.5119	0.7707	0.7707	1.8978	1.8978	0.8045	0.8045	4.38	4.38
Long-term Debt to Capitalization	0.4263	0.4263	0.6019	0.6019	0.4353	0.4353	0.6549	0.6549	0.4458	0.4458	0.81	0.81
Unrestricted Cash to Debt	1.0410	1.0410	0.1171	0.1171	0.8984	0.8984	0.1166	0.1166	1.3397	1.3397	0.80	0.80
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31	1.55	1.55	-10.27	-10.27
Equity Financing Ratio	2.38	2.38	5.16	5.16	2.40	2.40	6.56	6.56	2.83	2.83	14.85	14.85
D. Additional Statistics												
Income from Operations	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)	42,986	445,460	(4,454,655)	(14,149,342)
Revenue Over/(Under) Expense	(868,438)	(3,603,719)	(3,946,434)	(12,862,636)	(1,002,893)	(4,581,472)	(3,064,172)	(15,926,812)	(892,841)	(5,474,307)	(6,022,874)	(21,949,687)
Patient Cash Collected	20,638,288	208,125,604	21,041,111	200,383,967	19,923,196	228,048,799	19,137,425	219,521,392	22,806,351	250,855,150	20,336,820	239,559,240
Cash and Cash Equivalents	28,151,297	28,151,297	3,010,785	3,010,785	24,214,495	24,214,495	2,978,798	2,978,798	35,766,184	35,766,184	24,493,383	24,493,383
Net Working Capital	23,732,718	23,732,718	(1,022,164)	(1,022,164)	25,115,685	25,115,685	1,012,991	1,012,991	24,644,118	24,644,118	7,573,582	7,573,582
Unrestricted Assets	35,190,459	35,190,459	16,415,945	16,415,945	33,840,369	33,840,369	13,002,038	13,002,038	31,996,355	31,996,355	6,572,339	6,572,339
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

35. On page 878 of the Application, PMH's FY 2014 audited financial statements indicate that "*Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs*." Elaborate on the MEP process and success record. Indicate whether this program will be available at Waterbury Hospital if the asset purchase is approved and consummated.

Response:

Uninsured patients who receive services at PMH-affiliated hospitals are interviewed by either employees or third party contractors to determine if such patients are entitled to benefits from a variety of financial assistance programs, most notably state Medicaid. With the expansion of Medicaid under the ACA, many patients who present as uninsured are not aware that they could potentially qualify for Medicaid. Through the interview process, PMH hospitals determine if such patients qualify for Medicaid and assist such patients with submitting the appropriate forms to the relevant state agencies. In California, PMH estimates the success rate on assisting patients to qualify for financial assistance programs to be approximately 60%. In Texas, this success rate is approximately 15%. The success rate is lower in Texas because Texas did not opt for Medicaid expansion as part of the ACA. PMH has just recently instituted our MEP program in Rhode Island. As such, PMH has not had a chance to assess its success in Rhode Island.

OAG Questions

36. Your response to Question 10 in the Application states that the Independent Foundation will "seek qualification as a 501(c)(3) charitable organization." Please indicate how the Independent Foundation intends to qualify for such a designation.

Response:

The Independent Foundation will qualify as a charitable corporation under Section 501(c)(3) of the Internal Revenue Code as an entity that will be operated exclusively for charitable, religious, educational, and/or scientific purposes. The purposes of the Independent Foundation will be to support and carry out the purposes, missions and objectives of public charities and municipalities in Waterbury Hospital's current service areas including the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown, Wolcott and Woodbury (the "Communities") to the extent such purposes, missions and objectives exclusively support or promote the following purposes:

(a) the healthcare needs of the Communities;

(b) To support or conduct community health needs assessments and encourage and support efforts to improve the health of the Communities; and

(c) To support and engage in community projects, grants, activities and programs that will improve access to healthcare and enhance the health of the Communities, including the

provision of preventive health programs and health education, education and training of healthcare providers and educators in the Communities.

37. Exhibit Q10-2 is the Draft Bylaws of the Independent Foundation. In Section 4.1, it states: "At least a majority of the Trustees shall live or work in the Communities." Please explain why the bylaws do not require that all of the Trustees of the Independent Foundation either live or work in the communities served by GWHN.

Response:

While the Draft Bylaws do not require that all of the Trustees of the Independent Foundation either live or work in the communities served by GWHN, it is anticipated that they will do so. By not having such a requirement, the Independent Foundation is free to invite individuals who may have other close relationships to the community (e.g., recent residents) or have a particular expertise to offer to the Independent Foundation.

38. Your response to Question 11 in the Application states that the Hospital intends to continue to receive the income from several different types of charitable funds, including excess income from certain bed funds, until its liabilities are paid off. How does GWHN intend to apply the charitable income from these bed funds to provide free care for individuals while remaining in possession of the funds after the transaction closes? Also, please explain how GWHN will determine what is the *excess* income from such bed funds.

Response:

GWHN would remit income from the bed funds that allow excess income to be used for general purposes to whatever organization or entity is determined to be the appropriate recipient of all the other bed fund income that is restricted entirely to bed fund use. The amounts of those remittances would be based on certifications from the recipient(s) of other bed fund income of the amount of free bed care annually provided, for example, with respect to the Hopkins and Warner Funds, to residents of Naugatuck. After that income was paid over to the appropriate recipient, the excess income would be used by GWHN. The amount of the excess income would be determined by applying the same annual percentage payout made currently by corporate trustees (Bank of America, for example, with respect to the Abbie Hopkins Trust; currently 4.5%) from these funds, but deducting therefrom all funds paid out to the recipient of the bed fund portion of the income.

39. Please identify from which of the bed funds in Schedule D of Exhibit Q11-1 GWHN expects to continue to receive excess income.

Response:

GWHN expects to receive income from the following funds from Schedule D of Exhibit Q11-1:

- Margery K. Hayden (Elizabeth K. Hayden Fund)
- Merrit Heminway (Merrit Heminway Bed Fund)
- Abbie C. Hopkins
- Dwight H. Terry and Martha Terry (The Dwight H. and Martha J. Terry Fund)
- Olive Rogers Warner (The Richard Vincent Warner Memorial Fund)
- Estate of Oscar L. Warner (The Warner Memorial Fund)
- The Hopkins and two Warner Funds are of most importance given their size.

EXHIBIT Q7G-1

GWHN Remainder Hospital																
Expected Remaining Cash Balances																
Updated October 20, 2015 with 9/30/15 Net Proceeds Analysis			Pre-Closing	Post-Closing	Post Closing											
Years 1 through 10 Post Close																
			1st 6 Months FY	Last 6 Months FY	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY		
		9/30/2015	2016	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Totals	
Sales Price		25,000,000														
Target Working Capital @ 9/30/12		6,800,000														
Capital Lease Allowance	Estimated @ 9/30/15	0														
Total Purchase Price		31,800,000														
Less: Certain Liabilities Assumed by Joint Venture																
Nurses Pension	CHCA Pension Shortfall	(27,000,000)														
Non Union Pension	As of 9/30/15	(11,613,917)														
Asbestos Liability	As of 9/30/15	(2,898,529)														
Capital Lease Debt Assumed by Prospect	As of 9/30/15	0														
Net Enterprise Value		(9,712,446)														
Net Working Capital Adjustment ($11,401,512-$6,800,000)		4,601,512														
Cash proceeds to GWHN Before Expenses		(5,110,934)														
Less: Foundation Expenses																
FTC Counsel	Estimate	(50,000)														
Estimated Advisor Fees	Banker $800k Legal $600k	(1,400,000)														
Malpractice LPT and Tail (net of Captive Assets)	Assumed by Prospect	0														
Contingency		-														
Gross Cash Proceeds to "Oldco"		(6,560,934)														
Net Proceeds of Sale		(6,560,934)														
Gross Unrestricted Liquid Cash On Books at Closing @ 9/30/15	35,767,106															
Less: Immediate Payoff Of Certain Retained Liabilities																
CHEFA Debt	(23,789,744)	Per books 9/30/15														
CHEFA Interest Rate Swap	(1,512,596)	Per books 9/30/15														
Other Long Term Debt Debt	(304,894)	Assumed by Prospect														
	(25,607,234)															
Net Unrestricted Liquid Cash On Books At Closing After Payoff		10,159,872														
Estimated Remaining Cash @ 9/30/15		3,598,938														
Sources of Cash																
Projected Annual Unrestricted Endowment Income (exclude Hellman $10.2M)		$40M@.045%	900,000	900,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	19,800,000	
FY13 Medicare Cost Report		$543,596 rec'd in May 14, bal expected in FY16	225,821		0										225,821	
FY14 Medicaid Cost Report		To be Paid 7/31/15			7,377										7,377	
FY 14 Medicare Cost Report		estimated @9/30/14		(86,264)											(86,264)	
Workers Comp A/R Claims Settlement-Fairpay		To be rec'd 12/15	712,000												712000	
DSH Receivable FY 2015		File in 2016	0	560,202											560,202	
Meaningful Use Money related to FY 2014 & 2015-Hospital (Care and Caid)		As of 9/30/15	322,653		0										322,653	
Cancer Center Distribution		To be received in Dec '15	750,000	0											750,000	
FY 2015 Medicaid 10/1/4 to 12/31/14			0	(157,190)											(157,190)	
Estimated Investment Earnings		2.0% of annual avg cash	41,046	37,088	26,159	(24,447)	(51,134)	(54,735)	(49,050)	(40,221)	(28,663)	(14,676)	1,140	19,203	(138,291)	
Total Sources of Cash			2,951,520	1,253,836	1,833,536	1,775,553	1,748,866	1,745,265	1,750,950	1,759,779	1,771,337	1,785,324	1,801,140	1,819,203	21,996,308	21,996,308
Uses of Cash																
State of CT Dual Eligible Takeback			385,044												385,044	
Operating Losses 10/1/15 to 3/31/16		Includes $6.2M of Taxes	1,514,057												1,514,057	
Estimated RAC Payouts (Net of Recoveries)		Avg. past three years		250,000	500,000	500,000	500,000								1,750,000	
FY 2012 Medicare Cost Report Settlement-MU		As of 9/30/14	0	0											-	
Medicaid OP claim audit for 2010 to 2012		Completed	0	0											-	
Potential State reprocessing of SFY 2014 OP claims		eliminated @ 9/30/14		0											-	
FY 2011 Medicare Cost Report Settlement-Revised Cost Report		As of 9/30/14	0	0											-	
State of CT Sales Tax Payment for 1/1/16 to 3/31/16		Payable April, 2016	0		-										-	
Medicaid Outpatient audits (7/1/12 to 6/30/14)(7/1/14-3/31/16)		Based on most recent			1,400,000	1,225,000	0	0	0	0	0	0	0	0	2,625,000	
Medicaid RCC Recoupment		Accrued 9/30/15		1,410,000	-	0	0	0	0	0	0	0	0	0	1,410,000	
Subtotal			1,899,101	1,660,000	1,900,000	1,725,000	500,000	0	0	0	0	0	0	0	7,684,101	7,684,101

Other Foundation Expenses														-	
Cost of managing the Foundation	.5 FTE Exec Dir.	0	0	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	117,000	1,170,000	
Services Purchased from Prospect	See separate w/s	0	0	50,000	50,000	50,000	0	0	0	0	0	0	0	150,000	
Insurances	See separate w/s	0	0	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	26,000	260,000	
Children's Center Subsidy	Doubled current subsidy	0	0	-	-	-	-	-	-	-	-	-	-	-	
Health and Dental Claims Runout	IBNR Per Actuary	0	0	-	0	0	0	0	0	0	0	0	0	-	
Projected Annual funding of CHCA Withdrawal Liability	Per contract settlement	0	0	0	0	0	0	0	0	0	0	0	0	-	
Subtotal Other Foundation Expenses		-	-	193,000	193,000	193,000	143,000	143,000	143,000	143,000	143,000	143,000	143,000	1,580,000	1,580,000
Workers Comp Costs															
Claims Payments (from actuary report)	From 9/30/15 actuary rep		1,361,183	2,114,713	1,547,002	1,239,692	1,086,254	912,369	811,331	683,497	617,844	537,179	435,466	11,346,530	
State of CT 2nd injury Fund	.0587% of paid claims	-	79,901	124,134	90,809	72,770	63,763	53,556	47,625	40,121	36,267	31,532	25,562	666,041	
Excess Policy Premium	Will not need		0	0	0	0	0	0	0	0	0	0	0	-	
Fees for legal, L of C, Actuary, TPA	See separate w/s		0	256,500	231,500	181,500	181,500	181,500	181,500	166,500	166,500	166,500	166,500	1,880,000	
Subtotal Workers Comp Costs		-	1,441,084	2,495,347	1,869,311	1,493,962	1,331,517	1,147,425	1,040,456	890,118	820,611	735,211	627,528	13,892,571	13,892,571
Certain Fees															
Fees for Mercer (Investment Consulting)	To be negotiated	0		-	-	-	-	-	-	-	-	-	-	-	
Fees for BNY (Investments)	to be negotiated	0		-	-	-	-	-	-	-	-	-	-	-	
Accounting and Auditing	See separate w/s	0		100,000	75,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	575,000	
Legal Fees	Estimated	0		100,000	50,000	50,000	25,000	10,000	10,000	10,000	10,000	10,000	10,000	285,000	
Contract Cancellation Fees	Estimated	0	-	-	0	0	0	-	0	0	0	0	0	-	
Subtotal Certain fees		0	-	200,000	125,000	100,000	75,000	60,000	60,000	60,000	60,000	60,000	60,000	860,000	860,000
Liquidation of 9/30/14 Liabilities															
Repayment of Children's Center CHEFA Debt			752	9,840	9,840	10,660	10,660	11,480	13,612	13,612	13,612	13,612	13,612	121,292	
Repayment of Children's Center A/P	Not required	0	0	0	0	0	0	0	0	0	0	0	0	0	
HAIC Capital Call	Repaid April 2014	0	0	0	0	0	0	0	0	0	0	0	0	0	
Medicaid Outpatient Recoupment (cost to charge ratio)	recouped nov and dec 2013	0	0	0	0	0	0	0	0	0	0	0	0	0	
Repayment of FY 2012 Medicare Cost Report	check cut 1/29/14	0	0	0	0	0	0	0	0	0	0	0	0	0	
Repayment of 2013 SPA Payable	to be repaid starting 2/14	0	0	0	0	0	0	0	0	0	0	0	0	-	
Repayment of 2014 SPA Payable	to be repaid after 2/14	0	0	0	0	0	0	0	0	0	0	0	0	-	
Intentionally Left Blank		0	0	0	0	0	0	0	0	0	0	0	0	-	
Subtotal of 9/30/14 Liabilities		-	752	9,840	9,840	10,660	10,660	11,480	13,612	13,612	13,612	13,612	13,612	121,292	121,292
Total Uses of Cash		1,899,101	3,101,836	4,798,187	3,922,151	2,297,622	1,560,177	1,361,905	1,257,068	1,106,730	1,037,223	951,823	844,140	24,137,964	
Net change in Cash		1,052,419	(1,848,000)	(2,964,651)	(2,146,598)	(548,756)	185,088	389,045	502,711	664,606	748,100	849,316	975,063	(2,141,656)	
Estimated Cash On Hand End of Year		4,651,357	2,803,357	(161,293)	(2,307,892)	(2,856,648)	(2,671,560)	(2,282,515)	(1,779,804)	(1,115,198)	(367,097)	482,219	1,457,282	1,457,282	
Minimum Needed Per Agreement		0	0	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	0	0	0	0	0		
Excess/(Deficiency)		4,651,357	2,803,357	(4,661,293)	(6,807,892)	(7,356,648)	(7,171,560)	(6,782,515)	(1,779,804)	(1,115,198)	(367,097)	482,219	1,457,282	1,457,282	
Ending Cash Balance Before Investment Income		4,610,311	2,766,269	(187,452)	(2,283,444)	(2,805,514)	(2,616,825)	(2,233,465)	(1,739,583)	(1,086,534)	(352,421)	481,079	1,438,079		
Average Cash On Hand		4,104,625	3,708,813	1,307,952	(1,222,369)	(2,556,703)	(2,736,736)	(2,452,512)	(2,011,049)	(1,433,169)	(733,809)	56,991	960,149		
Investment Income (assumes 2.0% annual interest)		41,046	37,088	26,159	(24,447)	(51,134)	(54,735)	(49,050)	(40,221)	(28,663)	(14,676)	1,140	19,203		